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ABSTRACT

This manual presents the Project Head Start program goals and performance standards in the areas of education, health and nutrition services, social services, and parent involvement. A short discussion of general Head Start goals, performance standard development, implementation, and enforcement is included. Each performance standard is accompanied by guidance material which provides further information about the purpose of the standard and the methods and procedures for implementation. Appendices provide statements of policy concerning the development and implementation of program design variations for local Head Start programs as well as policy for the involvement of parents of Head Start children. (BRT)

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MANUAL
PART

CHAPTER

OCD-HS HEAD START POLICY MANUAL

OCD Notice N-30-364-4

HEAD START
PROGRAM PERFORMANCE STANDARDS

PS 008565

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CHAPTER N-30-364-4

OFFICE OF CHILD DEVELOPMENT NOTICE PROGRAM PERFORMANCE STANDARDS

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Subpart A—General

Sec. 1304.1-1 PURPOSE AND APPLICATION

This part sets out the goals of the Head Start program as they may be achieved by the combined attainment of the objectives of the basic components of the program, with emphasis on the program performance standards necessary and required to attain those objectives. With the required development of plans covering the implementation of the performance standards, grantees and delegate agencies will have firm bases for operations most likely to lead to demonstrable benefits to children and their families. While compliance with the performance standards is required as a condition of Federal Head Start funding, it is expected that the standards will be largely self-enforcing. This part applies to all Head Start grantees and delegate agencies.

Sec. 1304.1-2 DEFINITIONS

As used in this part:

(a) The term "OCD" means the Office of Child Development, Office of Human Development, in the U.S. Department of Health, Education, and Welfare, and includes appropriate regional office staff.

(b) The term "responsible HEW official" means the official who is authorized to make the grant of assistance in question, or his designee.

(c) The term "Director" means the Director of the Office of Child Development.

(d) The term "grantee" means the public or private nonprofit agency which has been granted assistance by OCD to carry on a Head Start program.

(e) The term "delegate agency" means a public or private nonprofit organization or agency to which a grantee has delegated the carrying on of all or part of its Head Start program.

(f) The term "goal" means the ultimate purpose or interest toward which total Head Start program efforts are directed.

(g) The term "objective" means the ultimate purpose or interest toward which Head Start program component efforts are directed.

(h) The term "program performance standards" or "performance standards" means the Head Start program functions, activities and facilities required and necessary to meet the objectives and goals of the Head Start program as they relate directly to children and their families.

(i) The term "handicapped children" means mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired children who by reason thereof require special education and related services.

Sec. 1304.1-3 HEAD START PROGRAM GOALS

(a) The Head Start Program is based on the premise that all children share certain needs, and that children of low income families, in particular, can benefit from a comprehensive developmental program to meet those needs. The Head Start program approach is based on the philosophy that:

(1) A child can benefit most from a comprehensive, interdisciplinary program to foster development and remedy problems as expressed in a broad range of services, and that

(2) The child's entire family, as well as the community must be involved. The program should maximize the strengths and unique experiences of each child. The family, which is perceived as the principal influence on the child's development, must be a direct participant in the program. Local communities are allowed latitude in developing creative program designs so long as the basic goals, objectives and standards of a comprehensive program are adhered to.

(b) The overall goal of the Head Start program is to bring about a greater degree of social competence in children of low income families. By social competence is meant the child's everyday effectiveness in dealing with both present environment and later responsibilities in school and life. Social competence takes into account the interrelatedness of cognitive and intellectual development, physical and mental health, nutritional needs, and other factors that enable a developmental approach to helping children achieve social competence. To the accomplishment of this goal, Head Start objectives and performance standards provide for:

(1) The improvement of the child's health and physical abilities, including appropriate steps to correct present physical and mental problems and to enhance every child's access to an adequate diet. The improvement of the family's attitude toward future health care and physical abilities.

(2) The encouragement of self-confidence, spontaneity, curiosity, and self-discipline which will assist in the development of the child's social and emotional health.

(3) The enhancement of the child's mental processes and skills with particular attention to conceptual and communications skills.

(4) The establishment of patterns and expectations of success for the child, which will create a climate of confidence for present and future learning efforts and overall development.

(5) An increase in the ability of the child and the family to relate to each other and to others.

(6) The enhancement of the sense of dignity and self-worth within the child and his family.

Sec. 1304.1-4 PERFORMANCE STANDARDS PLAN DEVELOPMENT

Each grantee and delegate agency shall develop a plan for implementing the performance standards prescribed in Subparts B, C, D, and E of this part for use in the operation of its Head Start program (hereinafter called "plan" or "performance standards plan"). The plan shall provide that the Head Start program covered thereby shall meet or exceed the performance standards. The plan shall be in writing and shall be developed by the appropriate professional Head Start staff of the grantee or delegate agency with cooperation from other Head Start staff, with technical assistance and advice as needed from personnel of the Regional Office and professional consultants, and with the advice and concurrence of the policy council or policy committee. The plan must be reviewed by grantee or delegate agency staff and the policy council or policy committee at least annually and revised and updated as may be necessary.

Sec. 1304.1-5 PERFORMANCE STANDARDS IMPLEMENTATION AND ENFORCEMENT

(a) Grantees and delegate agencies must be in compliance with or exceed the performance standards prescribed in Subparts B, C, D, and E of this part at the commencement of the grantee's program year next following July 1, 1975, effective date of the regulations in this part, or 6 months after that date, whichever is later, and thereafter, unless the period for full compliance is extended in accordance with paragraph (f) of this section.

(b) If the responsible HEW official as a result of information obtained from program self-evaluation, pre-review, or routine monitoring, is aware or has reason to believe that a Head Start program, with respect to performance standards other than those for which the time for compliance has been extended in accordance with paragraph (f) of this section, is not in compliance with performance standards, he shall notify the grantee promptly in writing of the deficiencies and inform the grantee that it, or if the deficiencies are in a Head Start program operated by a delegate agency, the delegate agency has a period stated in the notice not to exceed 90 days to come into compliance. If the notice is with respect to a delegate agency, the grantee shall immediately notify the delegate agency and inform it of the time within which the deficiencies must be corrected. Upon receiving the notice the grantee or delegate agency shall immediately analyze its operations to determine how it might best comply with the performance standards. In this process it shall review, among other things, its utilization of all available local resources, and whether it is receiving the benefits of State and other Federal programs for which it is eligible and which are available. It shall review and realign where feasible, program priorities, operations, and financial and manpower allocations. It shall also consider the possibility of choosing an alternate program option for the delivery of Head Start services in accordance with OCD Notice N-30-334-1, Program Options for Project Head Start, attached hereto as Appendix A, which the grantee, with OCD concurrence, determines that it would be able to operate as a quality program in compliance with performance standards.

(c) The grantee or delegate agency shall report in writing in detail its efforts to meet the performance standards within the time given in the notice to the responsible HEW official. A delegate agency shall report through the grantee. If the reporting agency, grantee or delegate agency determines that it is unable to comply with the performance standards, the responsible HEW official shall be notified promptly in writing by the grantee, which notice shall contain a description of the deficiencies not able to be corrected and the reasons therefor. If insufficient funding is included as a principal reason for inability to comply with performance standards, the notice shall specify the exact amount, and basis for the funding deficit and efforts made to obtain funding from other sources.

(d) The responsible HEW official on the basis of the reports submitted pursuant to paragraph (c) of this section, will undertake to assist grantees, and delegate agencies through their grantees, to comply with the performance standards, including by furnishing or by recommending technical assistance.

(e) If the grantee or delegate agency has not complied with the performance standards, other than those for which the time for compliance has been extended in accordance with paragraph (f) of this section, within the period stated in the notice issued under paragraph (b) of this section, the grantee shall be notified promptly by the responsible HEW official of the commencement of suspension or termination proceedings or of the intention to deny refunding as may be appropriate, under Part 1303 (appeals procedures) of this chapter.

(f) The time within which a grantee or delegate agency shall be required to correct deficiencies in implementation of the performance standards may be extended by the responsible HEW official to a maximum of one year, only with respect to the following deficiencies:

(1) The space per child provided by the Head Start program does not comply with the Education Services performance standard but there is no risk to the health or safety of the children;

(2) The Head Start program is unable to provide Medical or Dental Treatment Services as required by Health Services Performance Standards because funding is insufficient and there are no community or other resources available;

(3) The services of a mental health professional are not available or accessible to the program as required by the Health Services Performance Standards; or

(4) The deficient service is not able to be corrected within the 90 days notice period, notwithstanding full effort at compliance, because of lack of funds and outside community resources, but it is reasonable to expect that the services will be brought into compliance within the extended period, and the overall high quality of the Head Start program otherwise will be maintained during the extension.

INTRODUCTION

The Performance Standards presented in the following pages are accompanied by guidance material which elaborates upon their intent and provides methods and procedures for implementing them. The standard is found in the left hand column and the appropriate guidance material in the right hand column. The standards in the left hand column constitute Head Start policy with which all grantees and delegate agencies are required to conform. They are taken verbatim from the *Federal Register* dated June 30, 1975, Volume 40, Number 126, Part II, that contains the Head Start Program Performance Standards for operation of Head Start programs by grantees and delegate agencies. The guidance in the right hand column is provided for the assistance of Head Start programs in interpreting and implementing the standards and is not in itself mandatory.

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Subpart B—Education Services Objectives and Performance Standards

§ 1304.2-1 Education services objectives.

The objectives of the Education Service component of the Head Start program are to:

(a) Provide children with a learning environment and the varied experiences which will help them develop socially, intellectually, physically, and emotionally in a manner appropriate to their age and stage of development toward the overall goal of social competence.

(b) Integrate the educational aspects of the various Head Start components in the daily program of activities.

(c) Involve parents in educational activities of the program to enhance their role as the principal influence on the child's education and development.

(d) Assist parents to increase knowledge, understanding, skills, and experience in child growth and development.

(e) Identify and reinforce experiences which occur in the home that parents can utilize as educational activities for their children.

§ 1304.2-2 Education services plan content: operations.

(a) The education services component of the performance standards plan shall provide strategies for achieving the education objectives. In so doing it shall provide for program activities that include an organized series of experiences designed to meet the individual differences and needs of participating children, the special needs of handicapped children, the needs of specific educational priorities of the local population and the community. Program activities must be carried out in a manner to avoid sex role stereotyping.
In addition, the plan shall provide methods for assisting parents in understanding and using alternative ways to foster learning and development of their children.

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(a) The education plan should be prepared by the educational staff with cooperation from other Head Start staff, parents and policy group members. Professional consultants may be called upon as needed.

Before the education plan is written, parents, staff and policy group members should meet to discuss the education service objectives and performance standards. The staff has the responsibility to inform parents and policy group members about alternative strategies for achieving the education objectives. The staff should recommend those strategies (curriculum approaches, teaching methods, classroom activities, etc.) most appropriate to the individual needs of the population served and based on

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performance standard requirements. With the concurrence of the parents and policy group members, the educational staff will then write the plan. The education plan must be specifically designed to meet children's needs as determined through assessment procedures.

The education plan must specify strategies for implementing each of the education services objectives of the Head Start program.

The education plan should indicate:

- How the education program will provide children with a learning environment and varied experiences appropriate to their age and stage of development which will help them develop:

  socially
  intellectually
  physically
  emotionally

- How the education program will integrate the educational aspects of the various Head Start components in the daily program of activities.
- How the education program will involve parents in educational activities to enhance their role as the principal influence on the child's education and development.
- How the education program will assist parents to increase knowledge, understanding, skills, and experience in child growth and development.
- How the education program will identify and reinforce experiences which occur in the home that parents can utilize as educational activities for their children.

The plan should be accompanied by brief descriptive information regarding:

- Geographical setting
- Physical setting (available facilities)
- Population to be served (ethnicity, race, language, age, prevelance of handicapping conditions, health factors, family situations)
- Education staff (staffing patterns, experience, training)

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	- Volunteers - Community resources - Program philosophy/curriculum approach - Assessment procedures (individual child, total program) Refer to DHEW Publications: - Project Head Start Program Series Booklets: # 4, *Daily Program I* (OHD) 73-1016 #11, *Daily Program III* (OHD) 73-1023 #13, *Speech, Language, and Hearing Program* (OCD) 75-1025 - Caring for Children Series: #1. *The Ways Children Learn* (OHD) 75-1026 #2, *More than a Teacher* (OHD) 75-1027 #3, *Preparing for Change* (OHD) 75-1028 #4, *Away from Bedlam* (OHD) 75-1029 #5, *The Vulnerable Child* (OHD) 75-1030 - Child Development Day Care Series: #3, *Serving Preschool Children* (OHD) 74-1057 #8, *Serving Children with Special Needs* (OCD) 73-1063
(b) The education services component of the plan shall provide for:	(1) The following suggestions may be useful beginning steps:
(1) *A supportive social and emotional climate* which:	
(i) Enhances children's understanding of themselves as individuals, and in relation to others, by providing for individual, small group, and large group activities;	(i) Encourage awareness of self through the use of full-length mirrors, photos and drawings of child and family, tape recordings of voices, etc. - Use child's name on his work and belongings. - Arrange activity settings to invite group participation (block and doll corners, dramatic play). - Include active and quiet periods, child-initiated and adult-initiated activities, and use of special areas for quiet and individual play or rest.
(ii) Gives children many opportunities for success through program activities;	(ii) Here are some examples: - Make sure that activities are suited to the developmental level of each child; - Allow the child to do as much for himself as he can; - Help the child learn "self-help" skills (pouring milk, putting on coat);

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	• Recognize and praise honest effort and not just results; • Support efforts and intervene when helpful to the child; • Help the child accept failure without defeat ("I will help you try again."); • Help the child learn to wait ("You will have a turn in five minutes."); • Break tasks down into manageable parts so that children can see how much progress they are making.
(iii) Provides an environment of acceptance which helps each child build ethnic pride, develop a positive self-concept, enhance his individual strengths, and develop facility in social relationships.	(iii) This can be accomplished by adult behavior such as: • showing respect for each child; • listening and responding to children; • showing affection and personal regard (greeting by name, one-to-one contact); • giving attention to what the child considers important (looking at a block structure, locating a lost mitten); • expressing appreciation, recognizing effort and accomplishments of each child, following through on promises; • respecting and protecting individual rights and personal belongings (a "cubby" or box for storage, name printed on work in large, clear letters); • acknowledging and accepting unique qualities of each child; • avoiding situations which stereotype sex roles or racial/ethnic backgrounds; • providing ample opportunity for each child to experience success, to earn praise, to develop an "I can," "Let me try," attitude; • accepting each child's language, whether it be standard English, a dialect or a foreign language; fostering the child's comfort in using the primary language; • providing opportunities to talk about feelings, to share responsibilities, to share humor.
(2) Development of intellectual skills by:	(2) Intellectual skills can be enhanced by providing a learning climate in which staff guide children to foster cognitive functioning (i.e., understanding, reasoning, conceptualizing, etc.).
(i) Encouraging children to solve problems, initiate activities, explore, experiment, question, and gain mastery through learning by doing;	(i) Provide materials and time appropriate to the child's age and level of development in the areas of:

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	• science; concepts of size, shape, texture, weight, color, etc.; • dramatic play; • art; • music; • numerical concepts; spatial, locational and other relationships.
(ii) Promoting language understanding and use in an atmosphere that encourages easy communication among children and between children and adults;	(ii) Some examples are: • Give children ample time to talk to each other and ask questions in the language of their choice; • Encourage free discussion and conversation between children and adults; • Provide games, songs, stories, poems which offer new and interesting vocabulary; • Encourage children to tell and listen to stories.
(iii) Working toward recognition of the symbols for letters and numbers according to the individual developmental level of the children;	(iii) Make use of information that is relevant to the child's interests, such as his name, telephone number, address and age. Make ample use of written language within the context of the child's understanding, for example, experience stories, labels, signs.
(iv) Encouraging children to organize their experiences and understand concepts; and	(iv) The sequence of classroom activities should progress from simple to more complex tasks, and from concrete to abstract concepts. Activities can be organized around concepts to be learned.
(v) Providing a balance program of staff directed and child initiated activities.	(v) Although each day's activities should be planned by the staff, the schedule should allow ample time for both spontaneous activity by children and blocks of time for teacher-directed activities.
(3) Promotion of physical growth by:	
(i) Providing adequate indoor and outdoor space, materials, equipment, and time for children to use large and small muscles to increase their physical skills; and	(i) This can be accomplished through regular periods for physical activity (both indoor and outdoor). Physical activities should include materials and experiences designed to develop: • large muscles (wheel toys, climbing apparatus, blocks); • small muscles (scissors, clay, puzzles, small blocks); • eye-hand coordination (puzzles, balls, lotto); • body awareness; • rhythm and movement (dancing, musical instruments).

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(ii) Providing appropriate guidance while children are using equipment and materials in order to promote children's physical growth.	ii) Staff should be actively involved with children during periods of physical activity. During such activities, staff should take opportunities to increase their contact with individual children. To ensure safety, activities should be adequately supervised.
(c) The education services component of the plan shall provide for a program which is individualized to meet the special needs of children from various populations by:	
(1) Having a curriculum which is relevant and reflective of the needs of the population served (bilingual/bicultural, multicultural, rural, urban, reservation, migrant, etc.).	(1) This can be accomplished by including in each classroom materials and activities which reflect the cultural background of the children. Examples of materials include: • books; • records; • posters, maps, charts; • dolls, clothing. Activities may include: • celebration of cultural events and holidays; • serving foods related to other cultures; • stories, music, and games representative of children's background; • inviting persons who speak the child's native language to assist with activities.
(2) Having staff and program resources reflective of the racial and ethnic population of the children in the program.	
(i) Including persons who speak the primary language of the children and are knowledgeable about their heritage; and, at a minimum, when a majority of the children speak a language other than English, at least one teacher or aide interacting regularly with the children must speak their language; and	(i) This adult may be: • a teacher or aide • other member of the center staff • a parent or family member • a volunteer who speaks the child's language
(ii) Where only a few children, or a single child, speak a language different from the rest, one adult in the center should be available to communicate in the native language.	(ii) In some cases where a single child is affected it may not be possible for the center to provide an adult speaking the child's language on a regular basis.
(3) Including parents in curriculum development and having them serve as resource persons (e.g., for bilingual/bicultural activities).	(3) Parents can be valuable resources in planning activities which reflect the children's heritage. Teachers may request suggestions from parents on ways to integrate cultural activities into the program. For example, parents may wish to: • plan holiday celebrations; • prepare foods unique to various cultures;

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(d) The education services component of the plan shall provide procedures for on-going observation, recording and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs. It shall provide, also, for integrating the educational aspects of other Head Start components into the daily education services program.

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- recommend books, records, or other materials for the classroom;
- act as classroom volunteers;
- suggest games, songs and art projects which reflect cultural customs.

(d) The education plan should specify how Head Start staff will assess the individual developmental/instructional needs of children. Some ways this may be accomplished include:

- discussions with parents during recruitment, enrollment, home visits, parent-staff conferences and meetings;
- review of child's medical and developmental records;
- conferences with medical or psychological consultants where indicated;
- teacher observations documenting developmental progress used as guidance in planning for and/or modifying individual children's activities;
- use of specific assessment instruments or scales.

Planning should take into account the age groups and abilities of the children. For example, activities will differ for three and five year olds. Children with handicaps, like all children, should have specific goals set for them according to their ability.

The plan should also include the following:

- long-range plans based on evaluation of each child's current needs, interests and abilities;
- specific activities and responsibilities of staff members;
- consistent methods for observing and recording the progress of each child;
- procedures to be used for reviewing each child's progress and modifying the program when indicated.

Activities to integrate educational aspects of other components into the daily education program could include:

- *Health Education* built into the schedule through:

—time to talk about physical and dental examinations in order to increase understanding and reduce fears;

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—books and pictures about doctors and dentists;
—materials for dramatic play (stethoscope, nurse's uniform, flashlight);
—role playing before and after visits to doctors, dentists, hospitals, clinics, etc.

- *Nutrition Education* as part of the daily schedule:

—assistance in meal preparation, setting table;
—learning experiences through food preparation (adding liquids to solids, seasoning, freezing, melting, heating, cooling, cooking simple foods)
—books, pictures, films, trips related to the source of foods, (farm, garden, warehouse, market, grocery store).

Refer to Project Head Start Program Series Booklets:

- #2, *Health Services* (OCD) 73-1007
- #2A, *Dental Services* (OCD) 73-1008
- #3, *Nutrition* (OCD) 72-47
- #3E, *Leader's Discussion Guide for Nutrition Film*
- #3F, *Nutrition Education for Young Children* (OHD) 75-1015

(e) The plan shall provide methods for enhancing the knowledge and understanding of both staff and parents of the educational and developmental needs and activities of children in the program. These shall include:

(e) The plan should indicate some of the ways parents and staff will work together to understand each child and provide for his learning experiences. The plan should include details of ways the home and center will attempt to supplement each other in providing positive experiences for the child.

There should be an early orientation to the Education Services Objectives. Special emphasis should be given to the significance of the materials, equipment and experiences provided in a Head Start Child Development program. Interpreters should be available to facilitate full participation of non-English speaking parents.

Procedures should be established to facilitate maximum communication between staff and parents, for example:

- newsletters
- parent/teacher conferences
- group meetings
- phone calls
- home visits
- posters, bulletin boards, radio/TV announcements.

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(1) Parent participation in planning the education program, and in center, classroom and home program activities;	(1) Meeting with staff to provide for the overall written education plan (see item 1304.2-2(a) for further guidance).
(2) Parent training in activities that can be used in the home to reinforce the learning and development of their children in the center;	(2) Some examples are: • orientation and training sessions • designing activities for children at home • participating in classroom/center activities.
(3) Parent training in the observation of growth and development of their children in the home environment and identification of and handling special developmental needs;	(3) Provide parents with films, workshops, publications, specialists, professionals, etc., in child growth and development. Arrange for films, publications and specialists to provide training. Refer to DHEW Publications: • Caring for Children Series #10, *Language is for Communication* (OHD) 75-1035 • Children's Bureau Publication #30, *Your Child from 1 to 6* (OHD) 76-26
(4) Participation in staff and staff-parent conferences and the making of periodic home visits (no less than two) by members of the education staff;	(4) Areas of mutual concern to be discussed could include: • child's developmental progress; • child rearing issues; • discussion of possible home activities to expand the Head Start experience; • discussion of health problems or handicapping conditions of the Head Start child. Although only two home visits are required, we suggest that consideration be given to visiting each child's home at the beginning, middle and end of the year. Arrangements for such visits should respect parent's wishes and convience and should be coordinated with the visits of other component staff. At least one of these visits should be devoted to discussion with parents around areas of mutual interest and concern in order to identify home activities and other ways to expand the Head Start experience.
(5) Staff and parent training, under a program jointly developed with all components of the Head Start program, in child development and behavioral developmental problems of preschool children; and	(5) An orientation and training program should be planned in cooperation with other component staff members and parents. The training program should provide for periodic formal and informal sessions. The content, organization, staffing and scheduling will depend on the individual program needs as determined in the planning stage. Training should focus on the normal child as well as the child with

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	special needs. Emphasis should be on mental, physical, social, and emotional growth and development. There should be identification of opportunities for training or continuing education to contribute to staff competence. In some locations, CDA training can be an appropriate means for achieving this; many Head Start staff members are receiving CDA training through the Head Start Supplementary Training program. (Refer to DHEW Publication: *The CDA Program: The Child Development Associate—A Guide for Training* (OHD) 75-1065)
(6) Staff training in identification of and handling children with special needs and working with the parents of such children, and in coordinating relevant referral resources.	(6) Training should also familiarize staff and parents with appropriate referral resources in the community. (Refer to 1304.3-3(b)(10))
§ 1304.2–3 Education services plan content: facilities.	
(a) The education services component of the plan shall provide for a physical environment, conducive to learning and reflective of the different stages of development of the children. Home-based projects must make affirmative efforts to achieve this environment. For center-based programs, space shall be organized into functional areas recognized by the children, and space, light, ventilation, heat, and other physical arrangements must be consistent with the health, safety and developmental needs of the children. To comply with this standard:	(a) Indoor and outdoor space should be sufficient and appropriate for necessary program activities and for support functions (offices, food preparation, custodial services) if they are conducted on the premises. In addition, rest/nap facilities and space for isolation of sick children should be available. Refer to DHEW Publications: • #4, *Daily Program I*—(OHD) 73-1016 • Caring for Children Series #6 *A Setting for Growth* (OHD) 75-1031 • *Space for Learning* (OCD) 72-51
(1) There shall be a safe and effective heating system;	(1) Radiators, stoves, hot water pipes, portable heating units, and similar potential hazards are adequately screened or insulated to prevent burns.
(2) No highly flammable furnishings or decorations shall be used.	(2) Flammable materials can be fireproofed with commercial preparations.
(3) Flammable and other dangerous materials and potential poisons shall be stored in locked cabinets or storage facilities accessible only to authorized persons;	(3) Cleaning supplies and potentially dangerous materials should be stored separately from food and out of reach of children.
(4) Emergency lighting shall be available in case of power failure;	(4) High powered flashlights may be used. Candles are fire hazards.
(5) Approved, working fire extinguishers shall be readily available;	(5) Adults in the program should be able to locate and properly operate fire extinguishers.

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(6) Indoor and outdoor premises shall be kept clean and free, on a daily basis, of undesirable and hazardous material and conditions;	(6) If evidence of rodents or vermin is found, the local health or sanitation department may provide assistance or referral for extermination. At regular intervals programs should check for and correct splintered surfaces, extremely sharp or protruding corners or edges, loose or broken parts. All clear glass doors should be clearly marked with opaque tape to avoid accidents.
(7) Outdoor play areas shall be made so as to prevent children from leaving the premises and getting into unsafe and unsupervised areas;	(7) Where outdoor space borders on unsafe areas (traffic, streets, ponds, swimming areas) adults should always be positioned to supervise the children. If possible such areas should be enclosed.
(8) Paint coatings on premises used for care of children shall be determined to assure the absence of a hazardous quantity of lead;	(8) Old buildings may be dangerous; be sure to check for lead contamination. The local public health department can be contacted to provide information on lead poisoning and to detect hazardous quantities of lead in the facility.
(9) Rooms shall be well lighted;	(9) Fixtures which have a low glare surface to sufficiently diffuse and reflect light may be useful. Use bulbs with sufficient wattage. Check and replace burned-out bulbs regularly.
(10) A source of water approved by the appropriate local authority shall be available in the facility; adequate toilets and handwashing facilities shall be available and easily reached by children;	(10) Verify State and local licensing requirements in these areas. Stepstools or low platforms may be useful where toilets or handwashing facilities are too high.
(11) All sewage and liquid waste shall be disposed of through a sewer system approved by an appropriate responsible authority, and garbage and trash shall be stored in a safe and sanitary manner until collected;	(11) Disposal problems can be referred to the local sanitation and public work department. Keep all waste materials away from children's activity areas and from areas used for storage and for preparation of food.
(12) There shall be at least 35 square feet of indoor space per child available for the care of children (i.e., exclusive of bathrooms, halls, kitchen, and storage places). There shall be at least 75 square feet per child outdoors; and	(12) Where minimum space is not available, various alternatives can be considered. For example, a variation in program design (See OCD Notice N-30-334-1 on Program Options for Project Head Start), stagger the program day, the program week, outdoor play periods. In this manner, all children will not be present at the same time. In some cases, outdoor space requirements may be met by arranging for daily use of an adjoining or nearby school yard, park, playground, vacant lot, or other space. Be sure that these areas are easily accessible and fulfill the necessary safety requirements. In some cases, it may be necessary to locate more suitable facilities.

EDUCATION

PERFORMANCE STANDARDS	GUIDANCE
(13) Adequate provisions shall be made for handicapped children to ensure their safety and comfort.	(13) Ramps, railings, and special materials and equipment may be needed in order to allow such children maximum possible mobility. Community resources may be used to acquire needed special materials and services.
Evidence that the center meets or exceeds State or local licensing requirements for similar kinds of facilities for fire, health, and safety shall be accepted as prima facie compliance with the fire, health and safety requirements of this section.	Confirm compliance with local licensing requirements. Where no licensing is required, the grantee and Policy Council should request advice from local fire and health departments in determining safety standards.
(b) The plan shall provide for appropriate and sufficient furniture, equipment and materials to meet the needs of the program, and for their arrangement in such a way as to facilitate learning, assure a balanced program of spontaneous and structured activities, and encourage self-reliance in the children. The equipment and materials shall be:	(b) Refer to DHEW Publications: • Project Head Start Program Series Booklets: # 4, *Daily Program* (OHD) 73-1016 # 9, *Equipment and Supplies* #11, *Daily Program III* (OHD) 73-1023 • Caring for Children Series: # 6, *A Setting for Growth* (OHD) 75-1031 • Space for Learning (OCD) 72-51
(1) Consistent with the specific educational objectives of the local program;	(1) Make use of the written plan when selecting materials and equipment.
(2) Consistent with the cultural and ethnic background of the children;	(2) Many books, pictures, records, and other materials reflect ethnic and cultural heritage and background.
(3) Geared to the age, ability, and developmental needs of the children;	(3) For instance, chairs and tables are child size; toys, books, and other materials and equipment are interesting and challenging to the children.
(4) Safe, durable, and kept in good condition;	(4) Contact U. S. Consumer Product Safety Commission, Washington, D. C. 20207 for information. Repair broken equipment and materials promptly.
(5) Stored in a safe and orderly fashion when not in use; **(6) Accessible, attractive, and inviting to the children; and**	(5) (6) Securely - fastened, well - organized closets and cabinets are needed for many supplies which should be stored out of reach and sight of small children. Classroom materials and equipment, stored on low shelves and/or in open bins should be located near the area where they are to be used and arranged in orderly convenient fashion so that children may be responsible for their use and return to storage.
(7) Designed to provide a variety of learning experiences and to encourage experimentation and exploration.	(7) Materials that can be used in a number of ways rather than single-purpose items are generally more useful.

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PERFORMANCE STANDARDS	GUIDANCE
Subpart C—Health Services Objectives and Performance Standards	
§ 1304.3–1 Health services general objectives. The general objectives of the health services component of the Head Start program are to: (a) Provide a comprehensive health services program which includes a broad range of medical, dental, mental health and nutrition services to preschool children, including handicapped children, to assist the child's physical, emotional, cognitive and social development toward the overall goal of social competence. (b) Promote preventive health services and early intervention. (c) Provide the child's family with the necessary skills and insight and otherwise attempt to link the family to an ongoing health care system to ensure that the child continues to receive comprehensive health care even after leaving the Head Start program.	(a), (b), & (c) These are the aims toward which the program efforts should be directed.
§ 1304.3–2 Health Services Advisory Committee. The plan shall provide for the creation of a Health Services Advisory Committee whose purpose shall be advising in the planning, operation and evaluation of the health services program and which shall consist of Head Start parents and health services providers in the community and other specialists in the various health disciplines. (Existing committees may be modified or combined to carry out this function.)	In order to achieve the comprehensive goals, the health program must be planned by professionally competent people. Planning must take place early and must involve a wide cross-section of the professional health talent available in the community. Examples of people who could be involved in planning the health program of the Head Start Center include: a. Pediatricians and pediatric societies. b. General practitioners and the Academy of General Practice. c. Other physicians and the county and State medical societies. d. Local, regional, and State health offices. e. Child and general psychiatrists and their associations. f. Hospital administrators and their associations. g. Dentists and dental associations. h. Public health nurses, school nurses, and nursing organizations. i. Nutritionists and their associations. j. Optometrists and their associations. k. Psychologists and their associations.

l. Medical technologists and their associations.
m. Speech and hearing personnel and their associations.

The plan should indicate the number of parents, and specific health professionals on the health advisory committee; goals and objectives; and projected number of meetings.

Involving parents, health professionals and their organizations in planning will ensure that the health program is tailored to the needs of the children, and that it utilizes fully the resources available in the community without duplicating already existing services. The health professionals should be aware of common health practices in their community. The health advisory committee should develop guidelines to deal with health practices that may be potentially harmful to a child. Organizations and individuals who are involved in the early planning of a program are likely to cooperate fully in the implementation of the program.

§ 1304.3–3 Medical and dental history, screening, and examinations.

(a) The health services component of the performance standards plan shall provide that for each child enrolled in the Head Start program a complete medical, dental and developmental history will be obtained and recorded, a thorough health screening will be given, and medical and dental examinations will be performed. The plan will provide also for advance parent or guardian authorization for all health services under this subpart.

(a) As much pertinent health information as possible should be accumulated and recorded for each child. This should be performed as soon after the child is enrolled as is feasible. There are three main sources for such information: records of past medical care, teachers' observations, and interviews with parents or guardians.

Every effort should be made to obtain records or summaries of the significant medical care and immunizations that each child has received in the past. This information may be available from hospital clinics, private physicians, or health department-sponsored well-child clinics. In special cases, it may be desirable to obtain the mother's and infant's delivery and birth history from the hospital where the child was born, especially if the child now shows evidence of neurologic impairment. Written records of important health events are important supplements to the mother's recollection of such events. By acquiring such records before the physician performs his complete health evaluation, a great deal of repetition, wasted time, and unnecessary concern may be avoided.

An example of that type of information required is contained in CAP-HS Form 30.

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	The teacher is in an unusually good position to notice those children who may have health problems. The teacher observes the children for 15 to 30 hours a week, whereas the physician can only observe the child for 20 minutes to an hour. Poor coordination, hyperactivity, unintelligible speech, excessive tiredness, or withdrawal from others may be noted much more readily by a teacher than by either the parent, who usually has little basis for comparison, or the physician, who has a limited time of observation. The teacher may observe dental problems when children eat. Some formal provision should be made to be sure that teachers' observations of the children's health and behavior are available to the physician at the time of his medical evaluation. An example of the type of form and information the teacher should record is contained in CAP-HS Form 30, mentioned above. An example of a consent form is also contained within CAP-HS Form 30.
(b) Health screenings shall include:	(b) Screening tests should be carried out for all of the Head Start children. These are tests some of which may be performed by non-professional workers. They do not represent a complete evaluation, but they identify a group of children who require more complete professional evaluation. *Screenings should be completed within 90 days after child is enrolled or entered into the program.* It is important that the results of the screening as well as the complete medical and developmental history are available to the physician at the time of medical examination. The purpose of this is to identify children with needs and to alert the physician to problems requiring a more complete professional evaluation.
(1) Growth assessment (head circumference up to two years old) height, weight, and age.	(1) Head circumference measurement is not necessary after the child reaches two years of age. (A health professional should teach this procedure to para-professionals.) The results of careful height and weight measurements for each child should be recorded. A beam balance scale should be used for weights since ordinary bathroom scales may be inaccurate.

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(2) Vision testing.

GUIDANCE

Heights should be measured with the child standing straight with his back to a wall on which is mounted a paper, wooden, or metal measure. A straight-edged device rested on the child's head is held at right angle to the measure.

In interpreting height and weight measurements, one must remember that many normal, well-nourished children are small for their age. In evaluating poor nutrition and poor growth, the rate of growth of a child between two measurements separated in time is more important than a single measurement. For this purpose, and whenever available, weights and measurements which were obtained in previous health examinations, should be recorded on a graphic recording sheet. The small child who is growing at a normal rate is likely to be well-nourished and free from serious disease. Even a much larger child who is growing at an unusually slow rate may have some significant adverse condition affecting his health.

(2) The most appropriate visual screening test to be applied in any community can usually best be determined by the health services director in consultation with the group of health practitioners—ophthalmologists and optometrists—who will be responsible for the complete evaluation and treatment of those children selected for the screening tests. These specialists can determine the type of tests and the criteria for passing or failing which they feel are most appropriate. Health departments and school health programs often have well-established visual screening programs which can be applied readily to Head Start children.

When there is no established screening program and consultation from eye specialists is not available to a community, the National Society for the Prevention of Blindness* or its State or local chapters, or the Volunteers for Vision may assist in setting up a screening program.

If none of these resources is available, the following vision screening method may be used, which will generally identify most of the children who are in need of further eye care. The test may be performed by nurses, by health aides, or volunteers trained in the method.

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*Address: 79 Madison Avenue, New York, New York 10016.

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A Snellen E illiterate visual testing chart (obtainable from any hospital supply company or from the National Society for the Prevention of Blindness) should be placed on a bare wall without windows. There should be no bright light or glare within the child's field of vision. The child should be seated comfortably with his head 20 feet away from the chart. A goose-neck lamp with a metal shade and a 75 watt bulb placed 5 feet from the chart will provide adequate standard illumination.

Children should be instructed in the Head Start classroom, or in small groups before testing, in "how to play the E game." The child is told to indicate with his own fingers the direction in which the "fingers" of the E point. After he has learned to do this, each child is tested individually, a black "pirate's patch" may be a more acceptable way of covering one eye than simply holding a card in front of that eye. To avoid possible transfer of infection, a separate patch or card should be used for each child. The card or patch should not put any pressure on the eye, and the child should keep the covered eye open. First, the child's vision with both eyes is tested. Then, with his left eye covered, the child is asked to indicate which direction the E is pointing as the examiner uses a pencil or pointer to indicate specific symbols on the chart. An examiner may point first to the first E on the 20/60 line. If this is passed successfully, go on to the first two symbols on the 20/40 line. If these are passed successfully, go on to the first three symbols on the 20/30 line, and if these are passed successfully, go on to the 20/20 line. Whenever a child fails to identify the position correctly, the tester should continue across the same line on the E chart. A line is considered "passed" if more than one half of the figures on the line are correctly identified.

The same procedure is repeated with the right eye covered. A child fails the test if, with either eye, he is unable to identify more than half of the symbols on the 20/40 line or if there is more than a two line difference in vision between one eye and the other, even if the worse eye is 20/40 or better.

A child who is unable to learn to "play the E game" should be reported as "non-testable" may be given further instruction in the "E game," either in the classroom or by his parents at home, and retested at a later date.

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(3) Hearing testing.

GUIDANCE

Children already wearing glasses should be tested while wearing their glasses. If they pass the test while wearing their glasses, there is no need for further testing.

Children failing the test who appear acutely ill or particularly fatigued should be retested before they are referred to an eye specialist. Other children who fail the screening test should be referred to an eye specialist for further evaluation. The results of the screening test should be recorded on the child's health form and should be brought to the attention of the physician at the time of the health evaluation. At this time, the physician should examine the optic fundi with an ophthalmoscope and should note any deviation in extra-ocular movements.

(3) Children will be better prepared for testing if the procedure is demonstrated in the classroom, where the whole class can be made familiar with the sounds and taught to make the desired responses.

Children who cannot learn to respond to the test properly, or who give grossly inconsistent responses to sounds of any intensity, should be designated as "non-testable." A child is generally considered to have failed the screening test if he fails to respond at the recommended level at any frequency in either ear. The frequencies generally used in a limited hearing screening test are 1000, 2000, and 4000 Hz.

A large proportion of children who fail a hearing screening test has only temporary hearing impairment associated with upper respiratory conditions. Such children should be retested after a few weeks before they are referred for specialist medical or audiology care. For this reason, it is important to institute the hearing screening program as early as possible in the Head Start program or even before the Head Start classrooms begin to meet formally. Head Start officials may encourage school personnel to include hearing screening tests at part of the routine pre-school interview which many school systems conduct in spring before students will enter school.

Results of the preliminary hearing screening test should be recorded on the health form and be available to the physician at the time of his complete health evaluation.

The person performing a hearing screening test must have special training in the use of the equipment and in the interpretation of the various responses which children may make to the test. Most school health programs and health departments have both testing equipment and personnel trained in its use. If equipment and personnel are not available locally, help may be obtained from: (1) An audiologist in a neighboring community, (2) the regional or State health or education department, (3) the State speech and hearing associations, (4) the American Speech and Hearing Association*, (5) National Association of Hearing and Speech Agencies.** It will usually be more economical for a Head Start program in a smaller community to obtain services from a trained technician in a nearby larger community than to purchase its own equipment and train its own personnel.

(4) Hemoglobin or hematocrit determination.

(4) An accurate test of hemoglobin concentration is the best screening test for anemia. However, accurate tests require trained technicians and equipment that is moderately expensive.

The microhematocrit test is somewhat less precise as an indicator of anemia. However, the laboratory determination itself is so simple and accurate that this test could often be more practical than a hemoglobin test. Most community hospitals will have equipment to perform this test, as will many health department clinics.

In using either of these tests, blood samples may be obtained at the Head Start center or at another convenient place by a technician or nurse. The blood samples can then be transported and tested in a central location.

Children with anemia and similar medical nutrition problems need specific diagnoses and follow-up. A child with a hemoglobin of less than 11 or hematocrit of less than 34 is considered to be anemic. This is consistent with the standards of Public Health Service, Maternal and Child Health and with CDC National Nutrition Status Survey as well as EPSDT guidance material.

(5) Tuberculin testing where indicated.

(5) Tuberculin testing has the dual value of identifying children who may have tuberculosis, and of finding active cases of tuberculosis within the families or other intimate contacts of such children. Most Head Start programs will

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*Address: 9030 Old Georgetown Road, Washington, D. C. 20014.

**Address: 814 Thayer Ave., Silver Spring, Md. 20910.

be able to obtain both test materials and personnel trained in their use through their school health program, the local health department, or the local, county, or State tuberculosis association. Initial tuberculin testing is usually done at approximately one year of age.

Routine periodic tuberculosis testing is part of screening only if (1) the child has had contact with a known case of tuberculosis or is a member of a family with a history of tuberculosis, (2) *the child is living in a neighborhood or community in which the prevalence of tuberculin sensitivity in the school-age children is known to exceed 1%*, or (3) the child presents symptoms consistent with tuberculosis.

A Head Start program conducting its own tuberculosis testing program will usually find the tuberculin tine test to be the most economical and convenient. Materials for this test are available through many health departments and through any pharmacy. Complete instructions for administering and reading this test are packed with the test materials. The test should be scheduled at such a time that the children will be in a class three days later to have the test read. Any swelling or induration surrounding any of the four needle punctures should be considered a positive reaction.

Children who react positively to the tuberculin tine test should have a Mantoux intracutaneous test performed using either intermediate strength, PPD 0.1 mil., or OT 1/1000 0.1 ml. The Mantoux test must be performed by a physician or a specially trained nurse or technician. It should be read on the second or third day.

Since children who are known to have been exposed to an active case of pulmonary tuberculosis may have large, uncomfortable reactions to the standard screening test, they should be referred to a physician for testing with a more dilute perparation of PPD or OT. Certain viral infections (such as measles, influenza, mumps), some viral vaccines (such as measles and influenza) administration of corticosteroids, and extreme malnutrition may all depress or suppress the tuberculin reaction for as long as four to six weeks. Children with a history of such conditions should be retested at a later date.

The results of the test should be recorded and available to the physician at the time of his examination.

(6) A simple and inexpensive screening test that may detect some urinary tract abnormal-

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(6) Urinalysis.	ities is the use of a test paper which detects albumin, sugar, blood, and determines the pH of the urine. Urine can be obtained at the center or in the home using clean glass bottles or paper cups. The test paper is dipped in the urine and color changes on the paper are interpreted according to a chart enclosed on the test papers. Children whose test shows the presence of sugar, blood, more than 1+ albumin, or pH of more than 7.0 should have a complete urinalysis. Most children with abnormal screening urine tests will be found normal on careful retesting. Quantitative urine culture to discover bacteriuria is an important screening test for urinary tract abnormality. Unfortunately, this test is relatively expensive, and only a few Head Start communities will have the necessary bacteriologic laboratory facilities to perform the test economically and well. Diagnostic laboratory kits are now available for urine cultures which do not require bacteriological laboratory facilities. In those communities where economical and accurate testing is possible, this test should be considered for all girls. Boys who have enuresis (bedwetting) or other symptoms should be tested; asymptomatic boys do not require testing.
(7) Based on community health problems, other selected screenings where appropriate, e.g., sickle cell anemia, lead poisoning, and intestinal parasites.	(7) The local board of health, the pediatric consultant, and the health advisory committee provide information to ascertain whether sickle cell anemia, lead poisoning, and intestinal parasites are community health problems. Problems such as head lice can be dealt with in this manner.
(8) Assessment of current immunization status.	(8) Staff should check medical records and consult with parents on child's current immunization status regarding diphtheria, pertussis, tetanus, measles, polio, German measles, and mumps.
(9) During the course of health screening, procedures must be in effect for identifying speech problems, determining their cause, and providing services.	(9) Many children talk very little during a medical examination, and the physician is in a poor position to judge the adequacy of their speech. Efficient screening of very young children can be done quickly and informally by having children talk about stimulus pictures, repeat key words containing a variety of speech sounds,

and relate oral information spontaneously. In general, remedial speech services should be provided only where conditions exist which suggest that, without attention, a handicapping disorder will continue into late childhood.

The teachers in the Head Start center should make note of any children in their class whose speech is substantially different from that of the average Head Start child. These observations should be available to the physician at the time of his examination. He can then make special evaluations of the ears, palate, and larynx, and may be able to give advice as to whether the speech pattern is normally immature or is pathological for the child. Whenever speech and hearing professionals are available to the Head Start program, they should work in cooperation with the physician and teacher in detecting, examining, and evaluating speech abnormalities.

Every language community or geographic area has certain differences from so-called standard speech in pronunciation, vocabulary, and grammar. It should be recognized that a sizeable number of pre-schoolers have unclear speech due to immature articulation patterns and will mature and develop normally if they receive the necessary developmental services. Therefore, a child who may speak a language other than English or ethnic colloquialisms should not be regarded as speech impaired.

The health advisory committee should develop this procedure including the utilization of speech and hearing professionals and outlining a schedule for checking suspect speech abnormalities.

Services include speech and language development, clinical services, and parent counseling services.

(10) Identification of the special needs of handicapped children.

(10) Special needs of handicapped children can be identified from the screening and physical examination results, parent interviews, and teachers' and mental health professionals' observations.

The plan to provide for these special needs could include modification of the physical facility, modification of the curriculum, development of new or different feeding skills, and continuation of special medical care.

You will find the pamphlet "Responding to Individual Needs in Head Start" helpful in working with the children and the identification of resources.

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(c) Medical examinations for children shall include:

(1) Examination of all systems or regions which are made suspect by the history or screening test.

(2) Search for certain defects in specific regions common or important in this age group, i.e., skin, eye, ear, nose, throat, heart, lungs, and groin (inguinal) area.

(d) The plan shall provide, also, in accordance with local and State health regulations that employed program staff have initial health examinations, periodic check-ups, and are found to be free from communicable disease; and that volunteer staff be screened for tuberculosis.

§ 1304.3–4 Medical and dental treatment.

(a) The plan shall provide for treatment and follow-up services which include:

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A number of children may be receiving a predetermined set of screening services through public health clinics, neighborhood health centers, or Title XIX Medicaid Early and Periodic Screening, Diagnosis and Treatment, etc. If this set of screening services does not include all of those screenings herein required in the Performance Standards, Head Start must see that these screenings are provided.

(d) Staff and volunteers with respiratory infections, skin infections, or other types of communicable diseases should not have contact with the children.

Depending on conditions in the community, tuberculin testing, miniature chest X-rays or full-size chest films may be the most economical forms of screening.

Tuberculin screening is not necessary for the *occasional* volunteer.

(a) The purpose of all examinations and screening tests is to identify children in need of treatment. Examinations which do not lead to needed remedial or rehabilitative treatment represents a waste of time and money.

A person on the staff should assume responsibility for assuring that all health defects discovered actually receive competent and continuing care until they are remedied or until a pattern of continuing care for them has been well established. This should include:

Aid for the parent to find the necessary services and to find funds to pay for the services.

Assistance so that the parent and child actually have transportation to the physician or clinic, and that other children in the family can be cared for during the visit. Community resources should be used for these services.

Careful and repeated review of health records to assure that recommended treatment is act-

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(1) ***Obtaining or arranging for treatment of all health problems detected.*** **(Where funding is provided by non-Head Start funding sources there must be written documentation that such funds are used to the maximum feasible extent. Head Start funds may be used only when no other source of funding is available).**

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ually taking place and must plan to do whatever is necessary to ensure treatment and follow-up.

(1) The program should coordinate and supplement existing resources for health care of children; it should not duplicate them. When existing service programs do not meet the standards because of inaccessibility, unacceptability, or poor professional quality, funds may be used to supplement the existing services and bring them to standard. Only if existing services cannot be modified should new services be arranged or purchased.

Every community will have available many of the resources listed in the following table. The program may contract with existing agencies to provide some or all of the health services.

1. Private Practitioners of Medicine, Dentistry, Optometry, Psychology—individual or group.	1. May provide all types of health services (consultation and planning, administrative, examinations and screening tests, treatment, immunization, health education, and continuing health supervision) on a volunteer, contract, or fee-for-service basis.
2. Health Departments—city, county, regional, or State.	2. May provide all types of health services. Some may be free for all or some Head Start children as part of existing programs; some may be contracted for. May provide funds to purchase services from other sources.
3. School Health Programs.	3. Same possibilities as Health Department.
4. Clinics—run by hospitals, medical schools, or other agencies.	4. May provide all types of health services, usually on contract or fee-for-service, but some services may be free for all or some Head Start children.
5. Prepaid Medical Groups.	5. May provide complete range of services to children of members of group.
6. Armed Forces Medical Services.	6. May provide medical preventive, diagnostic, and treatment services to children of Armed Forces personnel. Dental services available only at remote posts.
7. Neighborhood Health Centers.	7. May provide comprehensive health services at no cost to Head Start for children living in geographically defined neighborhoods served by centers.
8. Comprehensive Child Health Centers (Example: Children and Youth Programs).	8. May provide comprehensive health services at no cost to Head Start children who are in the defined population served by the center.

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9. Dental Service Corporations.	9. May provide planning and administration of dental services for Head Start children on a contract fee.
10. Special Voluntary Agencies and Public Agencies.	10. May provide funds or services for screening or treatment and rehabilitation of certain health problems. Each is usually concerned with a single category of illness.
11. State Crippled Children's Programs.	11. May provide funds for services for screening or treatment and rehabilitation of certain health problems. Limited to certain categories of illness which vary from State to State and within States.
12. Local and State Welfare or Public Assistance Programs.	12. May provide funds for any or all health services for children whose families receive or are eligible for public assistance. Eligibility and type of service paid for vary by State and locality.
13. Insurance and Pre-Payment Plans.	13. Provide payment for certain kinds of health services for children of families covered by policies.
14. Medical Assistance under Title XIX "Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT)."	14. The majority of Head Start children are eligible for Medicaid EPSDT. This provides preventive health services for eligible Medicaid children through screening, diagnosing and treating children with health problems. Exact services provided and paid for and rules for eligibility vary from State to State. At this time, Arizona does not participate in Title XIX. (See Transmittal Notice 73.14 for further Information.)

SOME SPECIAL HEALTH AGENCIES WHICH MAY HELP WITH HEAD START HEALTH SERVICES

Catholic, Protestant, Jewish Welfare Associations.	Money for services, social services.
Family Service Associations.	Psychological, psychiatric and social services.
Lions Club.	Eyeglasses for needy children.
Other fraternal organizations, Civic Clubs, Women's Clubs, and Parent-Teachers Associations.	Money or volunteer help for special projects.
Associations for the blind or for prevention of blindness.	Vision screening, special services for vision-impaired children.
Associations for retarded children, cerebral palsy, crippled children and for children with special diseases.	Special services for retarded and handicapped children.

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Tuberculosis Associations.	Tuberculin testing and follow-up.
Mental Health Associations.	Psychological and social services, mental health consultations.

Resources need not be utilized solely because they are free. The utilization of community resources should be consistent with the Head Start goal of enhancing the sense of dignity and self-worth within the child and his/her family.

Ideally, each child should be examined by a private physician or by health facility staff who will institute corrective treatment for all defects discovered and who will also provide continuing health supervision for the child during the time that he/she is in Head Start and over the years to follow. One of the central goals of the Head Start program is to introduce a child and his parents to a physician or health facility that will be able to meet all of his health needs over an extended period of time.

(2) Completion of all recommended immunizations—diphtheria, pertussis, tetanus (DPT), polio, measles, German measles. Mumps immunization shall be provided where appropriate.

(2) Immunization instructions:

(a) "complete" immunization is defined as follows:

(i) DPT—at least three doses of DPT (Diphtheria, pertussis, tetanus) vaccine, the most recent within the past two years.

(ii) Polio—at least two doses of trivalent oral vaccine or three doses of monovalent oral vaccine plus one dose of trivalent vaccine.

(iii) Rubeola—Measles—one dose of live measles vaccine. Naturally occurring measles provides complete immunity.

(iv) Rubella—German Measles—one dose of live Rubella vaccine or serologically documented immunity.

(v) Mumps—where mumps vaccine is part of a combined vaccine it is appropriate for use in the immunization program. Naturally occurring mumps provides complete immunity.

The American Academy of Pediatrics schedule is an appropriate guide for immunizations.

(3) Obtaining or arranging for basic dental care services as follows:

(3) A staff member or dental hygienist may screen the child through checking the teeth for obvious holes or cavities, bleeding around the gums, and pus drainage.

Priorities for dental treatment are ordinarily:

(1) Children with painful teeth;

(2) Obvious cavities, bleeding gums, and pus drainage;

(3) Routine care for all children.

(i) Dental examination.

(i) The dental examination is an oral examination including diagnostic radiographs. Necessary treatment follows the examination. Examinations without treatment are of no value to the children or to the community.

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(ii) Services required for the relief of pain or infection.	
(iii) Restoration of decayed primary and permanent teeth.	
(iv) Pulp therapy for primary and permanent teeth as necessary.	
(v) Extraction of non-restorable teeth.	
(vi) Dental prophylaxis and instruction in self-care oral hygiene procedures.	(vi) Self-care oral hygiene should be emphasized daily in the classroom teaching and after meals. Cleaning of teeth (Dental Prophylaxis) and self-care oral hygiene (brushing, flossing, swishing) instructions may also be conducted simultaneously with the examination or may be conducted at the time of dental treatment.
(vii) Application of topical fluoride in communities which lack adequate fluoride levels in the public water supply.	(vii) The local health department, Department of Water and Sanitation, local dental health association, or USPHS Dental Consultant should be contacted to determine the adequacy of fluoride levels.
(b) There must be a plan of action for medical emergencies.	(b) A plan should be developed with the parents to provide for emergency medical care for their child. Written policy should deal with issues such as parental permission and consent forms to secure emergency care, transportation and available physicians, clinics and hospitals. A community physician, clinic or nurse should be available for telephone consultation at all times. At least one member of the full-time staff should be knowledgeable or become trained in first aid.
§ 1304.3–5 Medical and dental records.	
The plan shall provide for: (a) the establishment and maintenance of individual health records which contain the child's medical and developmental history, screening results, medical and dental examination data, and evaluation of this material, and up-to-date information about treatment and follow-up; (b) forwarding, with parent consent, the records to either the school or health delivery system or both when the child leaves the program; and (c) giving parents a summary of the record which includes information on immunization and follow-up treatment; and (d) utilization of the Health Program Assessment Report (HPAR); and (e) assurance that in all cases parents will be told the nature of the data to be collected and the uses to	The health records should be used for: (1) identifying needed preventive and corrective care, (2) arranging for such care, and (3) providing an educational program suited to the individual child. To aid the individual child, the record must completely, but concisely, summarize health findings as determined from the history, screening tests, and medical evaluation and must record all preventive measures in a way that clearly shows which recommended preventive measures have not yet taken place. Whenever a child is referred for consultation or treatment, all of the information in the health record should be made available to the consulting or treating professional. If this is not done, the consultant must either obtain and

which the data will be put, and that the uses will be restricted to the stated purposes.

record his own information, an unnecessary waste of time and effort, or proceed without such information, with possible ill effects for the child.

To aid physicians and health workers in providing needed health care, the record must provide a sufficient background of social, medical, and educational information of a general nature so that each health professional dealing with the child need not accumulate his own record and history.

To serve the educational needs of the child, health findings must be translated into classroom recommendations. This process should begin at the time the original health diagnoses are made. It must then be elaborated both by further written recommendations and by conferences between physicians, teachers, nurses, and other health personnel.

Records should indicate the progress in completing treatment for all conditions in need of follow-up as a result of screenings and medical examinations.

In order to be useful to health workers and individual children, the health records must contain a large amount of information of a confidential nature. The privacy and confidence of this information must be respected. The records should be kept in a place that is not accessible to unauthorized persons. Such information should not be available routinely to teachers, administrators, or other non-medical personnel. Those portions of the health information which are pertinent and useful to teachers and to administrative personnel should be shared with them through reports and through conferences which translate the confidential health information into useful educational and administrative recommendations. Health information must not be released to insurance companies or other inquiring agencies without written consent of child's parents or guardian.

Staff should review all health records with the parents. The summary should be given to parents so they have a written account of their current health status annually. In addition, a child's health record should be transferred to his/her school in order to ensure continuity of health services.

In order to complete the HPAR, the program must have complete up-to-date records. This instrument is used to assist the programs in self-assessment in the areas of planning, management, and delivery of health services.

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§ 1304.3-6 Health education.	
(a) The plan shall provide for an organized health education program for program staff, parents and children which ensures that:	(a) Health personnel should devote a substantial amount of time in helping the Head Start staff and parents understand the implications of health findings for individual children, and for the program in general. Regularly scheduled consultations between the physician and the teachers are suggested for this purpose.
(1) Parents are provided with information about all available health resources;	(1) A local health resource booklet or pamphlet should be prepared for distribution to parents. The information ought to be categorized by services.
(2) Parents are encouraged to become involved in the health care process relating to their child. One or both parents should be encouraged to accompany their child to medical and dental exams and appointments;	(2) Parents can learn about health as a continuing process and not just as a physical examination if they accompany the child to the examination.
(3) Staff are taught and parents are provided the opportunity to learn the principles of preventive health, emergency first-aid measures, and safety practices;	(3) Procedures should outline measures to be taken in a medical emergency at the center and the home. Preventive health topics can include prenatal and postnatal health, immunizations, sanitation, accident prevention, hazards of toxic lead paint, and first aid for cuts, bruises, insect bites, burns, and other specific community health problems. Staff should be aware of common health practices in their community.
(4) Health education is integrated into ongoing classroom and other program activities.	(4) The most important health education activity of a program is the example it sets by providing each child with pleasant, dignified, individualized care within the health program. Parents learn from the emphasis placed on careful examinations, immunizations, dental care, and other health measures that such health activities are important for their children. Parents' participation in classroom activities and in the health care process related to the child (screening, examinations) can be an effective method of health education for the entire family. Teachers should integrate health into the curriculum and daily activities of the children.
(5) The children are familiarized with all health services they will receive prior to the delivery of those services.	(5) Health education can build on the health services program in another way. Each screening test, immunization, and examination can be discussed in the classroom. This will serve both to prepare the children for an unusual experi-

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	ence and to give them a new knowledge about how each of these measures can contribute to their health. Children love to act out the experiences they have had with the doctor or nurse.
§ 1304.3–7 Mental health objectives. **The objectives of the mental health part of the health services component of the Head Start program are to:**	These are the outcomes toward which the program efforts should be directed.
(a) Assist all children participating in the program in emotional, cognitive and social development toward the overall goal of social competence in coordination with the education program and other related component activities; **(b) Provide handicapped children and children with special needs with the necessary mental health services which will ensure that the child and family achieve the full benefits of participation in the program;** **(c) Provide staff and parents with an understanding of child growth and development, an appreciation of individual differences, and the need for a supportive environment;** **(d) Provide for prevention, early identification and early intervention in problems that interfere with a child's development;** **(e) Develop a positive attitude toward mental health services and a recognition of the contribution of psychology, medicine, social services, education and other disciplines to the mental health program; and** **(f) Mobilize community resources to serve children with problems that prevent them from coping with their environment.**	
§ 1304.3–8 Mental health services. **(a) The mental health part of the plan shall provide that a mental health professional shall be available, at least on a consultation basis, to the Head Start program and to the children. The mental health professional shall:**	(a) A mental health professional is a child psychiatrist, a licensed psychologist, or a psychiatric nurse or psychiatric social worker. Both the psychiatric nurse and psychiatric social worker should have experience in working with young children. A mental health aide may be a member of the mental health team provided the aide is under the supervision of one of the above professionals. A mental health professional may be secured from a mental health center in the geographical areas, the school system, a university, or other

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	appropriate vendors capable of providing comprehensive mental health services.
(1) Assist in planning mental health program activities;	(1) The mental health professional should meet with the Head Start Director, the coordinator responsible for mental health services, and representative parents to assist in developing a plan for delivery of mental health services. The planning should focus on the setting of priorities according to program needs and availability of trained personnel and resources. Mental health program activities include: • pre-service and in-service training of teachers and aides; • consultation with teachers and teachers' aides; • work with parents; • screening, evaluation, and recommendations for intervention for children with special needs. The mental health professional should meet annually with appropriate staff and parents to assist in evaluation of objectives of the plan and to assist in revision of objectives for the following year.
(2) Train Head Start staff;	(2) Be involved in the assessment of mental health training needs, in designing the mental health training program, in the selection of trainers, and evaluating staff members' progress. Provide information which will help staff members better understand normal development as well as the more common behavior problems seen in children. Training should include observation techniques and methods in meeting the assessed needs of the child.
(3) Periodically observe children and consult with teachers and other staff;	(3) The mental health professional can provide practical advice and help to the teaching staff by observing the children in their physical surroundings at least semi-annually. Teachers can share their information, ideas, and suggestions about the children.
(4) Advise and assist in developmental screening and assessment;	(4) Advise and assist staff in devising a process for screening children with atypical behavior, and in evaluating children needing further assessment. In addition, the mental health professional will train or assist in obtaining training for teachers in use of behavior checklists and other screening instruments. Classroom observation and screening should

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	be initiated within the early weeks of class attendance and then continued on a periodic basis—as considered necessary by staff and/or mental health professional. Included in screening and evaluation are: • Physical coordination and development; • Intellectual development; • Sensory development with special emphasis on sensory discrimination; • Emotional development; • Social development.
(5) Assist in providing special help for children with atypical behavior or development, including speech;	(5) Advise and assist in provision of special services for children with atypical behavior or development, including language and speech. Through staff conferences, practical recommendations may be generated when working with the child with special needs. For example, the use of games aimed at increasing the child's verbal expression, how the staff may work with the overly shy or overly aggressive child, and how to curb impulsive behavior.
(6) Advise in the utilization of other community resources and referrals;	(6) The mental health professional should have a working knowledge of mental health resources in the community in order to assist in development of a file of community resources, including referral procedures and documentation of their use. Examples of such resource agencies include child guidance clinics, community mental health centers, psycho-educational clinics, and State or county children services.
(7) Orient parents and work with them to achieve the objectives of the mental health program; and	(7) Orient parents and work with them to achieve the objectives of the mental health program, including advising parents on how to secure assistance on individual problems, assisting center staff in developing an ongoing education in mental health for parents, and evaluating the effectiveness of the parent mental health education program. The mental health professional should help parents to recognize a variety of ways in which they can further their children's intellectual, emotional, and social development at home. This may be accomplished through individual or group meetings.
(8) Take appropriate steps in conjunction with health and education services to refer children for diagnostic examination to confirm that their emotional or behavior problems do not have a physical basis.	(8) When a child is referred for emotional or behavioral problems, a physical examination should be included in the assessment in order to rule out a physical cause for the mental health problem which can be treated.

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(b) The plan shall also provide	
(1) attention to pertinent medical and family history of each child so that mental health services can be made readily available when needed;	(1) The assessment of each child's medical records, family history and home visits by appropriate coordinators and teachers, for information, will indicate if the child or his family may need additional assistance from the mental health program. A plan for follow-through will be written for each child whose medical and/or family history and/or home visit suggests a potential for emotional or behavioral problems. The plan should include objectives to be evaluated monthly.
(2) use of existing community mental health resources;	(2) Procedures for utilizing existing community mental health resources including specified contact persons. These procedures should be developed in conjunction with the mental health professional for identifying and contacting resources.
(3) coordination with the education services component to provide a program keyed to individual developmental levels;	(3) The mental health professional and the educational coordinator should work closely with each teacher and the parents in designing an education program for each child based on his developmental level and in training teachers to be able to do such program planning. Conferences should be held periodically with the staff to discuss particular children who have been identified as needing special help. The mental health professional should share ideas and suggestions with staff on helping the child benefit from the program.
(4) confidentiality of records;	(4) Only authorized persons should be permitted to see the records. Parents and staff should jointly decide if such records are forwarded to the school system.
(5) regular group meetings of parents and program staff;	(5) Periodic group meetings at least quarterly, between parents and staff can be used for identifying and discussing child development, discipline, childhood fears, complex family problems, and other parental and staff concerns. A mental health professional should be present at these sessions periodically.
(6) parental consent for special mental health services;	(6) There must be a written consent from the parent for special mental health service. A standard "informed consent" form should be used and should include the following: the name of the child, the name of the service provider, a description of the services to be provided, and the date the form was signed.

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(7) opportunity for parents to obtain individual assistance; and,	(7) Opportunities should be provided for parents to discuss individual problems of the child or the family with the mental health professional. This can be done on an appointment basis.
(8) active involvement of parents in planning and implementing the individual mental health needs of their children.	(8) There should be a parent orientation meeting to explain the mental health program and the available services. Ideally, the mental health professional should conduct this meeting. Parents should be involved in developing and evaluating the mental health program.

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§ 1304.3–9 Nutrition objectives.

The objectives of the nutrition part of the health services component of the Head Start program are to:

(a) Help provide food which will help meet the child's daily nutritional needs in the child's home or in another clean and pleasant environment, recognizing individual differences and cultural patterns, and thereby promote sound physical, social, and emotional growth and development.

(b) Provide an environment for nutritional services which will support and promote the use of the feeding situation as an opportunity for learning;

(c) Help staff, child and family to understand the relationship of nutrition to health, factors which influence food practices, variety of ways to provide for nutritional needs and to apply this knowledge in the development of sound food habits even after leaving the Head Start program;

(d) Demonstrate the interrelationships of nutrition to other activities of the Head Start program and its contribution to the overall child development goals; and

(e) Involve all staff, parents and other community agencies as appropriate in meeting the child's nutritional needs so that nutritional care provided by Head Start complements and supplements that of the home and community.

§ 1304.3–10 Nutrition services.

(a) The nutrition services part of the health services component of the performance standards plan must identify the nutritional needs and problems of the children in the Head Start program and their families. In so doing account must be taken of:

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(a) The intended purpose of the written plan is to develop a system to:

- identify the problem areas and needs that must be addressed related to nutrition;
- meet total needs including providing the overall high quality feeding and nutrition education program expected for children, and
- bring parents and staff to a level of understanding and involvement in the area of nutrition to enable them to meet their various appropriate responsibilities.

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	It should be designed for the agency to use to develop and provide a high quality nutrition component and does not have to be elaborate. Appendix G, "Nutrition Component Program Planning" and Appendix H, "T/TA Plan of Action for the Nutrition Component," of the OCD *Handbook for Local Head Start Nutrition Specialists* can provide additional guidance to the professional staff responsible for developing the written plan. The Handbook is available through the OCD Regional Offices.
(1) The nutrition assessment data (height, weight, hemoglobin/hematocrit) obtained for each child;	(1) These data should be available from the child's current health evaluation record or his medical history record. Height and weight measurements should be plotted on growth charts at the beginning, middle and end of the school year. Other pertinent information can be obtained from the medical and dental records. Underheight/underweight children may need additional food provided at the center along with follow-up at home. Overweight children need follow-up to identify the specific factors involved in the weight problem and realistic interventions consistent with good child growth and development practices both at the center and at home. Children with anemia and similar medical nutrition problems need specific diagnoses and follow-up. A child with a hemoglobin of less than 11 or hematocrit of less than 34 is considered to be anemic. This is consistent with the standards of Public Health Service, Maternal and Child Health and with CDC National Nutrition Status Survey as well as EPSDT guidance material. Children with unresolved nutrition-related needs should be referred to appropriate agencies who have continuing contact with the child for follow-up after the child leaves Head Start.
(2) Information about family eating habits and special dietary needs and feeding problems, especially of handicapped children; and,	(2) This information should be obtained by talking with parents early in the year. The interviewer should receive orientation and training on how to conduct such interviews. Examples of the type of information to be solicited are contained in *Screening Children for Nutritional Status: Suggestions for Child Health Programs,* 1971. DHEW HSM 72–5603. Available from Maternal & Child Health, Health Services Admin., Public Health Service, 5600 Fisher's Lane,

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	Rockville, Maryland 20852. The information will be used to assure that the many good aspects of the family eating patterns are reinforced through food served in the center; that special dietary needs are met at the center; and that this information will be considered in developing a nutrition plan with families.
(3) Information about major community nutrition problems.	(3) Information about major community nutrition related problems may be obtained from the demographic characteristics of the target group such as family income, educational level, racial and ethnic composition, religion, and from the quality of the local food and water supply such as availability of enriched food staples, fluoridated water, etc. See *Nutrition Assessment in Health Programs*. Am. J. Public Health, vol. 63, November 1973, Supplement. Available from American Public Health Association, 1015–18th St., N.W., Washington, D.C. 20036 ($4.00) for a discussion of this subject. The State and local health department nutritionists are helpful in obtaining such information. The information should be used for developing the applied aspects of the nutrition program by determining the need for income supplementation, fluoridation of water, increased use of iodized salt, control of sale of uncertified raw milk, more effective method of distribution and utilization of food stamps, a system for making food available, i.e. transportation, food outlets, coops, etc.
(b) The plan, designed to assist in meeting the daily nutritional needs of the children, shall provide that:	(b) The child's total daily nutritional needs should be supplied by the food served in the home, complemented by the food served at the center.
(1) Every child in a part-day program will receive a quantity of food in meals (preferably hot) and snacks which provides at least ⅓ of daily nutritional needs with consideration for meeting any special needs of children, including the child with a handicapping condition;	(1) The Recommended Dietary Allowances of the National Research Council, National Academy of Sciences are used as the basis for establishing the nutritional needs of the child. Foods in the pattern shown under (b)(4) meet these needs. Calculations of nutrients in food served can be compared to the Recommended Dietary Allowances as a cross-check in assuring that one-third of the nutrient needs are met if there is any question of the adequacy of the meals. To meet ⅓ of the daily nutritional needs, use the lunch or supper pattern *plus* a breakfast or snack pattern. If the morning breakfast is used as the main meal rather than lunch or supper, it must be *very* substantial and include

a protein-rich food in addition to milk to help meet ⅓ the daily nutrient needs. In addition, the snack served must also be carefully planned to add fruit or vegetable and probably milk in order to meet the remaining nutrient needs.

Use of menu cycles (3 weeks or longer) are helpful in formulating balanced and varied menus and in planning purchasing orders and work schedules. Include hot and cold foods and variety in colors, flavors and textures. Seasonal foods and USDA donated commodities should be fully utilized to keep food costs down. Check children's acceptance of food items on menu periodically and make changes accordingly.

Menus should be dated, labeled accurately and posted in the food preparation area as well as in the dining area. All substitutions must be indicated on the posted menus and menu at food preparation site.

Choose foods for meals and snacks that contribute not only to the child's nutrient needs but also to good dental health and support the dental education program. Do not serve overly sweet and sticky foods especially those high in refined sugars.

The nutrient needs of handicapped children are the same as for other children. However, due to difficulties in chewing or swallowing or lack of feeding skills the texture and consistency of the foods may need to be modified. In other conditions which require modification of the menu such as in food allergies, digestive or metabolic disturbances, etc., this information should be part of the child's health record and a physician's prescription must be kept on file at the center and at the food preparation site and updated periodically. A qualified nutritionist should help plan for meeting these needs.

General use of special dietary foods such as vitamin fortified modified milk products either as snacks or as meal supplements are not allowed. They are not in keeping with Head Start nutrition program goals of (1) providing needed nutrients through well planned meals, (2) providing a variety of food and eating experiences, and (3) providing opportunities for children to participate in menu planning and wherever possible in simple food preparation and selection, (4) reinforcing cultural and ethnic practices found in the children's homes.

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(2) Every child in a full-day program will receive snack(s), lunch, and other meals as appropriate which will provide ½ to ⅔ of daily nutritional needs depending on the length of the program;

(3) All children in morning programs who have not received breakfast at the time they arrive at the Head Start program will be served a nourishing breakfast;

(4) The kinds of food served conform to minimum standards for meal patterns;

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(2) To meet ⅔ the child's nutrient needs will necessitate the use of the lunch or supper pattern *plus* breakfast and a snack or plus two well planned snacks, one of which contains milk. Even so calorie intake using the suggested quantities is generally inadequate, so it is critical to have seconds available and use butter or margarine as appropriate.

(3) Since it is virtually impossible for small children to meet their nutrient needs without having 3 meals a day, breakfast is required to be available at the center for children who have not had it at home. Breakfast should be served immediately upon arrival of the child at the center. If only a small number of the children arrive without breakfast, concentrate on supplementing the snack with simple additional foods to meet the breakfast pattern and serve the snack early. All children should then have access to this. If a majority of the children come without breakfast, it may be simpler to serve breakfast to all children.

The use of the grain/fruit product or fortified cake roll made to meet specifications as a replacement for the bread and/or cereal and fruit components of the breakfast pattern is not consistent with Head Start philosophy and thus is not acceptable. They neither satisfy the need for meeting cultural food preferences nor the need for using the feeding program to teach sound food habits and attitudes by introducing the child and family to a wide variety of nutritious foods available in the market. In addition to this cake roll, pastries, doughnuts, sugar-coated cereals, etc., because of their sweet and sticky nature are not supportive of Head Start dental health education and are not recommended.

(4) Meal Patterns

Programs on SFSP reimbursement should also check USDA requirements for meal patterns.

Breakfast

Juice or Fruit		Juice or Fruit
Cereal		Protein-rich food
Milk (part used for cereal)	OR	Bread, enriched or whole grain
Butter or Margarine, as needed.		Milk

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Snack—one or more of the following:

Milk, fruit, vegetable, juice or Protein-rich food

Lunch or Supper

Protein-rich food—main dish
Vegetable and/or fruit (at least 2 kinds)
Bread, enriched or whole grain
Butter or fortified margarine as needed
Milk

Snacks should be planned to supplement nutrient needs not met in the meals. (USDA-SFSP requires a bread-stuff plus milk, fruit or juice.)

Menus developed from the pattern can include cultural foods. For example, at lunch the meat or meat substitute, vegetable and bread could be made into an enchilada, taco or burrito using the meat or cheese or bean, tomatoes or tomato sauce and onion and an enriched corn or flour tortilla.

Protein-rich foods are meat, poultry, fish, eggs, cheese, peanut butter, dried peas and beans.

Fruit drinks and beverages made from fruit-flavored powders or syrups are not acceptable. They do not contain many of the vitamins and minerals found in natural juices.

Bread includes tortillas, cornbread, rolls, muffins, bagel, fried bread, flat bread, etc., made of whole grain or enriched flour. The use of whole grain bread and cereals is preferred.

"Milk" can be any type of fluid milk that meets State and local standards. The use of chocolate flavored milk is discouraged. Because it is sweet, it may satisfy the child's hunger before the child has eaten enough food to meet other nutrient needs. In addition, it is poor dental practice.

Raw vegetables contain larger amounts of vitamin C than cooked vegetables. Include both raw and cooked fruits and vegetables in the menu.

A good to excellent source of vitamin C should be served daily. Fruits and vegetables that are good to excellent sources of vitamin C in the quantities consumed are listed below:

Excellent: Orange, orange juice, grapefruit, grapefruit juice, broccoli, collards, cantaloupe, raw tomato and raw strawberries.

Very Good: Mustard, beet and turnip greens, kale, cauliflower, chard, tangerine, and tomato juice.

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(5) The quantities of food served conform to recommended amounts indicated in OCD Head Start guidance materials; and,

(6) Meal and snack periods are scheduled appropriately to meet children's needs and are posted along with menus; e.g., breakfast must be served at least 2½ hours before lunch, and snacks must be served at least 1½ hours before lunch or supper.

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Good: Spinach, raw green pepper, dandelion greens, raw cabbage.

A dark yellow or leafy green vegetable should be served every other day to provide vitamin A. Fruits and vegetables that are good to excellent sources of vitamin A are:

Sweet potatoes, carrots, pumpkin, broccoli, winter squash, apricots, peaches, tomatoes, cantaloupe, dark green leafy vegetables: beet and turnip greens, spinach, kale, collard, etc.

(5) Since children's appetites vary, average serving size for specific age groups are suggested below:

	AGES		
	1	2-3	4-6
Milk	½-1 c.*	½-1 c.	¾-1 c.
Bread	½ sl.*	½-1 sl.	1-1½ s.
Cereal	¼ c.	⅓ c.	½ c.
Vegetable			
Vit. A Source	2 T.*	3 T.	4 T.
Other	2 T.	3 T.	4 T.
Fruit			
C Source	¼ c.	⅓-½ c.	½ c.
Other	2 T.	3 T.	4 T.
Meat, lean cooked without bone	½ oz.*	1-1½ oz.	1½-2 oz.
Egg	1	1	1
Dried Peas or Beans, cooked	1 T.	2-3 T.	3-4 T.
Peanut Butter	1 T.	2-3 T.	3-4 T.
Cheese, cheddar	½ oz.	1-1½ oz.	1½-2 oz.
Cottage cheese	1 T.	2-3 T.	3-4 T.
Butter or Margarine	½ t.*	1 t.	1 t.

Remember that both these amounts and the amounts mandated by the USDA-SFSP are minimums and are guides. Some children may need more than these amounts. Check the USDA guides for their mandated amounts.

* NOTE
c. = cup
sl. = slice
T. = Tablespoon
oz. = ounce
t. = teaspoon

(6) Quiet time should be scheduled before the meal so the children come to the table relaxed and ready to eat. Regularity in times of serving meals and snacks and the following of a daily routine help young children to establish good habits. Proper spacing of meals allows time for the child to be hungry enough to eat. Time should be allowed after meals for activities such as toothbrushing, handwashing, etc.

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	This is especially important when the meal is served just before the children go home.
(c) The plan shall undertake to ensure that the nutrition services contribute to the development and socialization of the children by providing that:	(c) The feeding situation should promote the physical, social and emotional development of children. This needs to take place in a quiet, well-lighted and ventilated area. Meal-related activities provide opportunities for decision making, learning to take responsibility, sharing, communicating with others, muscle control and eye-hand coordination. Family style food service supports these efforts. Food-related activities should be planned from the very simple to more difficult, all within the child's range of abilities. Usually food preparation activities are coordinated with and may be carried out in the kitchens. If food is not prepared on-site, special efforts will need to be made to assure that opportunities are available for food preparation activities in the classroom. These will need to be closely coordinated with the planned menus.
(1) A variety of foods which broaden the child's food experience in addition to those that consider cultural and ethnic preferences is served;	(1) Start with familiar foods which make a child feel comfortable and promote good self-concept. Introduce new foods gradually. Offer a small amount of one new food along with a meal of familiar foods. Children should be prepared for the new food through classroom activities such as reading stories about the food, shopping for the food and helping in its preparation, growing the food or seeing it grow on a farm, etc. Snack time can be used to introduce a new food. Explore various ways one food item is served in different cultures. For example, the many different types of breads used: tortillas, biscuits, pita (flat bread), bagels, soda bread, etc. Explore the many ways one food can be prepared. For example: hard and soft cooked egg, fried, poached, coddled, egg salad, deviled, meringue, egg nog, etc.
(2) Food is not used as punishment or reward, and that children are encouraged but not forced to eat or taste;	(2) If a child refuses a food, offer it again at some future time, don't keep pestering the child. Forcing children to eat or using desserts or other food as reward or punishment may create problem eaters and unpleasant or undesirable associations with the food. Remember that all foods offered should contribute to the child's needs, including the dessert. "Clean plate" clubs, stars and other gimmicks to encourage children to eat are not appropriate.

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(3) The size and number of servings of food reflect consideration of individual children's needs;	(3) Appetites vary among children and in the same child from day to day. Start with small portions allowing for additional portions as desired. Permitting children to serve themselves gives them latitude to make decisions on the quantity they want and prevents waste. Family style food service is preferred. Use of pre-packaged (e.g. preplated TV type) meals is unacceptable. They allow no opportunity for individualization of serving size, and usually allow little variety, especially in cultural foods. Serve food in a form that is easy for the young child to manage. Bite-size pieces and finger food are well-liked and suitable for small hands. Meat cut in bite-size pieces, bread, and raw vegetables cut in strips and fruit in sections are easy for children to handle.
(4) Sufficient time is allowed for children to eat;	(4) Serve children as soon as they come to the table. Slow eaters should be allowed sufficient time to finish their food (about 30 minutes). If children become restless before the meal period is over allow them to get up and move around, i.e., the children can take their plate to a cleaning area away from the table when finished. A leisurely meal time pace should be encouraged. Some handicapped children may be eating at a different developmental level than the other children. For example, if the 3-year-old child is eating with skills of a 2-year-old, start where the child is and plan with a nutritionist or other therapist for helping the child reach an adequate level of self-feeding skill. See booklets: *Feeding the Handicapped Child*, Mary Ann Harvey, Editor. Available from: University of Tennessee, Child Development Center, Department of Nutrition, 711 Jefferson Avenue, Memphis, Tennessee 38105 Cost: $3.50; and *Feeding the Child with a Handicap*, Publication No. (HSM) 73–5609 for suggestions on feeding techniques for handicapped children and types of feeding utensils available. Available from Supt. of Documents, Government Printing Office, Washington, D.C. 20402 Cost: $.60.
(5) Chairs, tables, and eating utensils are suitable for the size and developmental level of the children with special consideration for meeting the needs of children with handicapping conditions;	(5) Heavy duty plastic dishes and stainless steel flatware are practical for use with small children. Small flat-bottom plastic glasses or cups (4 oz.) are easy to hold and help avoid spills. Small pitchers can be handled by children for refills. Forks should have broad short handles and short blunt tines. Spoons should

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	have shallow bowls. Children need experience using knives. These should have rounded tips and short handles. If paper plates must be used they should be of sturdy weight so that they do not slide around and so juice does not soak through the surface and make eating difficult. Paper or styrofoam tumblers are not suitable. The children squeeze the paper with obvious results of spillage and bite through the styrofoam. Disposable plastic flatware is unacceptable. It is a safety hazard and it is not conducive to development of eating skills. Most local sanitary codes should permit stainless flatware to be washed in hot soapy water, rinsed and boiled or sanitized by an approved bleach or other chemical method. Use washable tabletops, covers or mats for easy cleaning of spills.
(6) Children and staff, including volunteers, eat together sharing the same menu and a socializing experience in a relaxed atmosphere; and	(6) Small groups of 5–7 persons are conducive to conversation and interaction. Interesting and pleasant table conversation centered about children's total experiences (not limited to food and nutrition) should be encouraged. Discourage talk about personal dislike of food. Teachers and other adults should set a good example by their attitude toward acceptance of food served. If the teacher must be on a special diet and cannot eat the same foods as the children, this should be explained to them. Good food habits are "caught rather than taught." The cost of food for teachers, volunteers and parents as guests should be budgeted. (USDA Special Food Service Program for Children does not reimburse food costs for adults.)
(7) Opportunity is provided for the involvement of children in activities related to meal service. (For example: family style service)	(7) Activities related to meal service include shopping for food, food preparation, setting the table, serving the food to others or self, cleaning up, helping the cook, making place mats and table centerpieces, etc. Children should be allowed to help with all of these activities.
(d) The plan shall set forth an organized nutrition education program for staff, parents and children. This program shall assure that:	(d) An organized program is based on identified needs and consists of planned activities to meet these needs. Nutrition education helps staff, children and parents increase knowledge, understanding and skills to achieve good nutrition.
(1) Meal periods and food are planned to be used as an integral part of the total education program;	(1) Meal periods are part of the flow of the day's activities. Foods serve as objects of observation and conversation for conceptual, sensory, and vocabulary development of children.

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	Food related activities can be used as a means for teaching language arts, color, texture, arithmetic, science, social skills and hygienic practices; however, the primary purpose of these activities is to establish long term sound food habits and attitudes, and the food should be eaten. There also may be a special nutrition focus in the education program with carry over into the menu and meal time activities. For example, if a trip is planned to an orchard, related emphasis should be placed on the fruit in the menus, meal time conversation, and classroom food preparation experiences.
(2) Children participate in learning activities planned to effect the selection and enjoyment of a wide variety of nutritious foods;	(2) Examples of learning activities are field trips, tasting parties, food preparation, planting and growing food, reading stories about food; role playing as parents, grocer, making scrap books and exhibits, feeding classroom pets, planning menus to share with parents, etc.
(3) Families receive education in the selection and preparation of foods to meet family needs, guidance in home and money management and help in consumer education so that they can fulfill their major role and responsibility for the nutritional health of the family;	(3) Staff should talk with parents to identify nutrition information and food needs and develop the plan in response to their specific needs. "Education" may mean organizing food coops, group gardens, transportation systems and other activities that contribute to meeting the needs. Parents have much to offer each other. Many ways can be used for parent involvement in education such as formal and informal presentations, individual counseling by nutritionist, nurse and other staff, attendance at local adult education programs and cook training sessions. Also, parents can participate in menu planning committees and staff can distribute pamphlets, newsletters and employ audio-visual aids.
(4) All staff, including administrative, receive education in principles of nutrition and their application to child development and family health, and ways to create a good physical, social and emotional environment which supports and promotes development of sound food habits and their role in helping the child and family to achieve adequate nutrition.	(4) This education must be appropriate to the specific nutrition-related responsibilities of each staff member. For example, nutrition education for the classroom staff should have a different focus from that of the food service staff or that of the director. The staff training program should be coordinated and integrated with the total staff training and orientation program.
(e) The plan shall make special provision for the involvement of parents and appropriate community agencies in planning, implementing, and evaluating the nutrition services. It shall provide that:	(e) Parents should be encouraged to participate in nutrition program activities such as planning menus and working in classroom nutrition activities, to serve as volunteers or in jobs in food service and in on-going monitoring of the nutrition component.

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	Parents or members of the community who meet the following requirements should be encouraged to apply for food service positions: • know how to prepare good food • are willing to try out new foods • meet health standards • have good attitudes toward food • like being and working with and around children • are eager and flexible to learn the necessary competencies to carry out the functions required.
	Appropriate agencies can provide professional input and are resources for training teachers, staff and food service personnel as well as meeting needs of parents. It is important that these agencies understand the Head Start philosophy. Some agencies may be resources for additional funding for equipment, food, etc. Examples are local health departments, schools, colleges, hospitals, county extension service, professional and trade organizations (The American Dietetic Association, Dairy Council, Home Economics Association, etc.)
(1) The Policy Council or Committee and the Health Services Advisory Committee have opportunity to review and comment on the nutrition services;	(1) The health advisory committee and policy council should review the nutrition program plan and advise on specific needs of the program with special reference to addressing identified community nutrition needs.
(2) The nutritional status of the children will be discussed with their parents;	(2) Any problem related to nutritional status as identified in (a)(1) and (2) and by teachers' observations of feeding skills and habits should be discussed with parents. A plan to solve the problems should be developed with the parents. Opportunity should be taken to reinforce the positive food habits and good growth pattern of the child.
(3) Information about menus and nutrition activities will be shared regularly with parents;	(3) Information can be shared by sending menus to the home, periodic group meetings, parent-staff discussions, home visits, and periodic newsletters. Frequency of these activities will vary from agency to agency.
(4) Parents are informed of the benefits of food assistance programs; and	(4) Food assistance programs include food stamps, free or reduced price school breakfast, lunch, and food programs for high risk categories (pregnant mothers, infants, children, the elderly). Contact USDA Food & Nutrition Serv-

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	ice for materials and information on these programs. Food & Nutrition Service U.S. Dept. of Agriculture 500 12th Street, S.W. Washington, D.C. 20250
(5) Community agencies are enlisted to assist eligible families participate in food assistance programs.	(5) It is important to assure that families have food. This may involve utilization of emergency food banks, providing transportation to buy food stamps or food, etc.; but it should be remembered that the long term goal is to help families become independent. Work with the social service component on this.
(f) The plan shall provide for compliance with applicable local, State and Federal sanitation laws and regulations for food service operations including standards for storage, preparation and service of food, and health of food handlers, and for posting of evidence of such compliance. The plan shall provide, also, that vendors and caterers supplying food and beverages comply with similar applicable laws and regulations.	(f) These are established to protect the health and safety of children being fed. All food service personnel should possess a Health Card or Statement of Health from the local Health Department or physician. Some States do not send inspectors to check Head Start facilities for compliance with local and State standards. In such a situation, designated program personnel—with knowledge of applicable sanitation laws and regulations or sanitation standards that assure provision of a safe food service should check annually for compliance with these regulations and be responsible for the correction of existing violations. Written evidence of this must be available. Self-inspection reports should be completed quarterly to assure maintenance of standards. The following areas should be addressed: Cleanliness and safety of food before, during and after preparation including maintenance of correct temperature Cleanliness and maintenance of food preparation, service, storage and delivery areas and equipment Insect and rodent control Garbage disposal methods Dishwashing procedures and equipment Food handling practices Health of food service personnel Water supply Local or State sanitarians in health agencies can be most helpful in providing ideas on ways to meet sanitation standards. Evidence must be available that food caterers have met codes. Vehicles used for transporting and holding food must be insulated so food meets temperature standards and transportation equipment must be able to be sanitized.

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(g) The plan shall provide for direction of the nutrition services by a qualified full-time staff nutritionist or for periodic and regularly scheduled supervision by a qualified nutritionist or dietitian as defined in the Head Start Guidance material. Also, the plan shall provide that all nutrition services staff will receive preservice and in-service training as necessary to demonstrate and maintain proficiency in menu planning, food purchasing, food preparation and storage, and sanitation and personal hygiene.

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(g) The services that a nutritionist is expected to provide in developing, implementing and supervising a high quality feeding and nutrition program require a person with at least the minimal amount of nutrition training and experience as follows:

A qualified nutritionist can be one who (1) meets the educational and training requirements for membership in the American Dietetic Association plus *one* year of experience in community nutrition including services to children 0–6 *or* (2) has a baccalaureate degree with a major in foods and nutrition, dietetics or equivalent hours of food and nutrition course work plus *two* years of experience in community nutrition including services to children 0–6. Required experience could have been concurrent with or a part of training.

It is important that the same nutritionist be used to establish consistency and continuity in the services. The amount and frequency of supervision needed will depend on the size of the program and the help it needs in coming into compliance with the performance standards. *A minimum of 8 hours of services per month per center* is suggested. Field experience indicates that grantees with on-site food preparation facilities can effectively use the services of one full time nutritionist for every 10 sites. Grantees providing food from a centralized food preparation facility, including catered or contract services, can use one full time nutritionist for every 10–15 centers served. Nutritionists even though meeting the qualifications outlined above must be oriented in Head Start Performance Standards. Every nutritionist should be provided with the *Handbook for Local Head Start Nutrition Specialists* obtained from Office of Child Development Regional Offices.

The nutritionist provides the following types of services:

(1) Assesses the nutritional status and special needs of children and their families from information provided by the family and from the health records, discussions with nurse, physician, dentist, and from knowledge of community nutrition problems; helps parents and staff in formulating plans for the nutrition program from this information.

(2) Provides necessary counseling for parents.

(3) Plans the nutrition education program with

staff, parents and children. Participates in staff training.

(4) Observes performance of food service personnel and provides for a training program that will improve or develop competencies to insure proficiency.

(5) Helps teaching staff plan and provide nutrition-related learning experiences in classroom.

(6) Utilizes community resources in carrying out the total nutrition program.

(7) Participates in menu planning and review and takes other steps to assure a high quality feeding program.

(8) Provides the food service unit with direction in food budgeting, purchasing, storage, preparation, service, and setting up of efficient record systems.

(9) Assists in interpreting and meeting health, sanitation, and safety standards related to nutrition.

(10) Interprets Head Start nutrition service philosophy to peers in other agencies and enlists skills of such personnel.

(11) Assists in preparation of job descriptions and schedules in food preparation facility to assure an efficient food service operation.

(12) Assists in preparation of the budget and any written plans for the nutrition component.

(13) Participates in the self-assessment process.

The nutritionist should work at the grantee or delegate agency level so that she can coordinate all nutrition efforts across the board. She can function in several modes—using local resources in each program independently, setting up a cluster of model centers at which training of personnel can be conducted, scheduling her own time to make a monthly visit to each on-site facility (or however frequently this is feasible depending on the need in centers).

Training for food service staff must focus on knowledge, skills and attitudes needed to do the job as well as career development plans for those interested. The training program can be designed to meet the qualifications for a dietary technician or assistant as defined by the American Dietetic Association and provide opportu-

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(h) The plan shall provide for the establishment and maintenance of records covering the nutrition services budget, expenditures for food, menus utilized, numbers and types of meals served daily with separate recordings for children and adults, inspection reports made by health authorities, recipes and any other information deemed necessary for efficient operation.

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nity for career ladders into hospital dietary departments and other types of institutions.

Examples of duties which food service personnel may be expected to perform and therefore need training are:

- Plan menus with staff and parents
- Procure and store food, supplies, equipment
- Prepare or supervise the preparation and service of nutritious meals and snacks
- Arrange work schedules for aides and volunteers
- Maintain established standards of sanitation, safety and food preparation
- Prepare budget data and maintain cost control system
- Identify equipment needs
- Maintain records pertaining to food service operation
- Develop and test recipes and products
- Cooperate and participate in nutrition education activities for children, parents and staff
- Prepare simple written reports

Adequate numbers of staff and time are required to do this. What constitutes an adequate number of food service personnel depends on the size of the food operation (the number of children being fed), the type of equipment available, the level of compentency of the employees, and the available auxiliary help such as janitorial service and volunteers. One full time cook on basis of past Head Start experience is suggested for centers serving 30–40 children supplemented by one full time aide for centers serving up to 80 children. For centers serving 15–30 children, a minimum of 6 hours per day of cook's time is needed.

Sufficient paid time should be allotted to food service personnel to attend staff meetings, training and for planning.

(h) The nutrition services budget includes costs of food, food service and nutrition staff, equipment and nutrition education materials and supplies for children and parent activities and staff training.

Records should be kept on file for a minimum of 3 years and should be available to monitors, auditors and other agency personnel as needed.

All food program costs should be recorded: quantity and cost of food, purchased or do-

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nated, labor including volunteers, expenditures for equipment, utilities and transportation.

Programs under the Special Food Service Program must supply reports according to the requirements of the agency administering the program.

A daily count of meals served to children and adults is a requirement of USDA as a condition for reimbursement.

All menus should reflect any changes made.

Written inspection reports should be posted and indicate any sanitation violations and date of compliance or expected compliance.

Suggested sources of recipes are:

USDA–FNS–86—*Quantity Recipes for Child Care Centers*. USDA sends these recipes to programs participating in SFSP. See nutrition guidance (e)(4) for address.

Tested recipes are recommended to insure uniform quality, prevent waste and serve as a guide to purchasing.

Other needed records include food and equipment inventories, personnel evaluation and training records.

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Subpart D-Social Services Objectives and Performance Standards	
§ 1304.4–1 Social services objectives.	
The objectives of the social services component of the performance standards plan are to:	
(a) Establish and maintain an outreach and recruitment process which systematically insures enrollment of eligible children.	
(b) Provide enrollment of eligible children regardless of race, sex, creed, color, national origin, or handicapping condition.	
(c) Achieve parent participation in the center and home program and related activities.	
(d) Assist the family in its own efforts to improve the condition and quality of family life.	
(e) Make parents aware of community services and resources and facilitate their use.	
§ 1304.4–2 Social services plan content.	
(a) The social services plan shall provide procedures for:	(a) Input into the plan should be made by staff and parents.
(1) Recruitment of children, taking into account the demographic make-up of the community and the needs of the children and families;	(1) The recruitment process should systematically seek out children from the most disadvantaged homes. Recruitment techniques include door to door contact, use of income eligibility lists, and use of recruitment staff who can identify with the community. Special emphasis should be placed on recruiting and enrolling from and coordinating with other agencies which are serving only some of the children's needs.
(2) Recruitment of handicapped children;	(2) The following factors will be taken into account: • Number of handicapped children in the target population, including types of handicaps and their severity. • Services provided by other community agencies.
(3) Providing or referral for appropriate counseling;	(3) (4) Preferably, these services should be available directly from the local Head Start program. If unavailable directly, provision should

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(4) Emergency assistance or crisis intervention;	be made for obtaining appropriate services from outside resources.
(5) Furnishing information about available community services and how to use them;	(5) The procedure should ensure that all available community resources are used to the maximum extent possible.
(6) Follow-up to assure delivery of needed assistance;	(6) Agencies to whom children or other family members were referred should be contacted to assure the services were satisfactorily provided.
(7) Establishing a role of advocacy and spokesman for Head Start families;	(7) Head Start staff should, in a prudent and positive way, represent the best interests of Head Start families to the community and other community agencies, especially if the family has any problems in receiving benefits from local resources.
(8) Contacting of parent or guardian with respect to an enrolled child whose participation in the Head Start program is irregular or who has been absent four consecutive days; and	(8) Social services staff should make regularly scheduled family contacts (preferably home visits) and should assess and re-assess family needs on a continuing basis. These contacts should be coordinated with other component staff.
(9) Identification of the social service needs of Head Start families and working with other community agencies to develop programs to meet those needs.	(9) The procedure should specify those services which will be provided *directly* by the local Head Start program; *i.e.*, counseling and those services which will be provided by resource agencies other than the local Head Start program. Head Start staff should make every effort to involve parents in identifying individual family needs and in planning ways to meet those needs. Head Start staff should be provided training in how to identify families and children in need of social services.
(b) The plan shall provide for close cooperation with existing community resources including:	
(1) Helping Head Start parent groups work with other neighborhood and community groups with similar concerns;	(1) (2) Some form of official communication could be established through designated liaison to maintain contact with public service agencies. Letters of intent should be sought from agencies cooperating with Head Start where possible. Staffs should initiate the effort of finding out (inventorying) what services these agencies currently do offer and have the potential for offering in the future.
(2) Communicating to other community agencies the needs of Head Start families, and ways of meeting these needs;	
(3) Helping to assure better coordination, cooperation and information sharing with community agencies;	(3) Ways of facilitating communication with other social service providers in the community include visiting those providers, inviting those providers to visit the Head Start program, placing providers on a special Head Start mailing

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	list to receive pertinent information, being placed on the providers' mailing list to keep abreast of the providers' activities, and developing a media relations program with local press, radio stations, and TV stations.
(4) Calling attention to the inadequacies of existing community services, or to the need for additional services, and assisting in improving the available services, or bringing in new services; and	(4) A Social Service Advisory Committee comprised of Head Start staff, staff from other community agencies, and Head Start parents could be formed to provide input concerning needed social services and to act as an advocacy group in obtaining these services.
(5) Preparing and making available a community resource list to Head Start staff and families.	(5) In communities where another agency prepares a community resource list, the Head Start program might update the list and make it more relevant for Head Start purposes.
(c) The plan shall provide for the establishment, maintenance, and confidentiality of records of up-to-date, pertinent family data, including completed enrollment forms, referral and follow-up reports, reports of contacts with other agencies, and reports of contacts with families.	(c) Adequate records should be kept and reviewed periodically at the center level. Social service staff can coordinate with teaching staff on class attendance and follow-up. Parents and staff should be involved in determining criteria for confidentiality.

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Subpart E-Parent Involvement Objectives and Performance Standards

§ 1304.5–1 Parent involvement objectives.

The objectives of the parent involvement component of the performance standards are to:

(a) Provide a planned program of experiences and activities which support and enhance the parental role as the principal influence in their child's education and development.

(b) Provide a program that recognizes the parent as:
(1) Responsible guardians of their children's well being.
(2) Prime educators of their children.
(3) Contributors to the Head Start program and to their communities.

(c) Provide the following kinds of opportunities for parent participation:
(1) Direct involvement in decision making in the program planning and operations.
(2) Participation in classroom and other program activities as paid employees, volunteers or observors.
(3) Activities for parents which they have helped to develop.
(4) Working with their own children in cooperation with Head Start staff.

§ 1304.5–2 Parent involvement plan content: parent participation.

(a) The basic parent participation policy of the Head Start program, with which all Head Start programs must comply as a condition of being granted financial assistance, is contained in Head Start Policy Manual, Instruction I-31—Section B2, The Parents (OCD Transmittal Notice 70.2, dated August 10, 1970). This policy manual instruction is set forth in Appendix B to this part.

(b) The plan shall describe in detail the implementation of Head Start Policy Manual, Instruction I-31—Section B2. The Parents (Ap-

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(b) The written plan should include a general statement of objectives for the Parent Involvement component, a listing of specific

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pendix B). The plan shall assure that participation of Head Start parents is voluntary and shall not be required as a condition of the child's enrollment.	goals, and the appropriate methodology for achieving these goals. An example of a goal might be *Involving Parents in the Education Program* and one technique of the methodology for achieving this goal could be *Recruiting Parents to Serve as Classroom Volunteers.* Emphasis should be placed on maintaining the Head Start philosophy in the home so that parents' lives are enriched and the objectives of Head Start are continued by the child and the child's parents in the home or community.
§ 1304.5–3 Parent involvement plan content: enhancing development of parenting skills. **The plan shall provide methods and opportunities for involving parents in:**	
(a) Experiences and activities which lead to enhancing the development of their skills, self-confidence, and sense of independence in fostering an environment in which their children can develop to their full potential.	(a) Parents should be encouraged to participate in Head Start policy group and on community boards of directors and committees. Parents should be given the opportunity and encouraged to conduct sessions for staff, children, and other parents in relevant activities for which they have special skills. Parents should be encouraged to participate as volunteers in social service activities making contact with community social agencies and making home visits as well as volunteering in the classrooms.
(b) Experiences in child growth and development which will strengthen their role as the primary influence in their children's lives.	(b) Parents could be provided with training in child development concepts through such means as films, brochures, discussion groups, rap sessions, courses, books and parent-child interaction activities in home or center.
(c) Ways of providing educational and developmental activities for children in the home and community.	(c) Parents could be exposed to specific activities which foster learning in children in the home, *e.g.*, the use of common household items to teach the names of colors, as in "Bring me the blue towel," and in the community, *e.g.*, planning a trip to the store. Detailed guidance on program activities that could be utilized by Head Start programs are contained in the following: (1) A Guide for Planning and Operating Home-Based Child Development Programs. (2) Home Start Evaluation Executive Summary. (3) Home Start and Other Programs for Parents and Children (Conference Report).
(d) Health, mental health, dental and nutritional education.	(d) Training could be made available to parents, either in conjunction with staff training in

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	these areas or as a unit by itself. To facilitate parental attendance at training sessions, parents should receive adequate notice and babysitting services should be provided.
(e) Identification, and use, of family and community resources to meet the basic life support needs of the family.	(e) Parents should be provided or made aware of available community resources, such as adult classes in consumer education, financial assistance programs, and family and employment counseling. This ought to be coordinated with the social services component to avoid duplication of effort and to strengthen the family-centered approach of Head Start.
(f) Identification of opportunities for continuing education which may lead towards self-enrichment and employment.	(f) Educational opportunities might include basic adult education classes; continuing education programs, vocational training or child development associate (CDA) training, and self-enrichment programs. Resources in the local community and its immediate environs which offer programs in these and other educational areas should be identified and arrangements made for the participation of Head Start parents. Where these resources are inadequate or do not exist in close physical proximity, Head Start staff should seek assistance from the State training and technical assistance resource or from the OCD Regional Office. Many Head Start staff members are receiving training through the Head Start Supplementary Training Program.
(g) Meeting with the Head Start teachers and other appropriate staff for discussion and assessment of their children's individual needs and progress.	(g) Head Start staff should encourage parental interest in their child's development. Parents should be given the opportunity to meet with teachers on a scheduled and as-needed basis throughout the year (*e.g.*, three home visits are recommended, although only two are required, at the beginning, middle, and end of the school year). At these meetings parents and teachers should discuss the child's physical, social/emotional, and intellectual development and review the child's progress. Such meetings can be used to arrive at agreement regarding desirable short-range goals and some discussion of specific activities and experiences which may contribute to the child's progress toward these goals. Home visits should be planned to enable staff to acquire a fuller understanding of each child's abilities and experiences. Such visits may also be used to help parents consider the child's current needs, interests and ability in order to plan home activities and interactions

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§ 1304.5–4 Parent involvement plan content: communications among program management, program staff, and parents.

(a) The plan shall provide for two-way communication between staff and parents carried out on a regular basis throughout the program year which provides information about the program and its services; program activities for the children; the policy groups; and resources within the program and the community.

Communications must be designed and carried out in a way which reaches parents and staff effectively. Policy groups, staff and parents must participate in the planning and development of the communication system used.

(b) The plan shall provide a system for the regular provision of information to members of Policy Groups. The purpose of such communication is to enable the policy group to make informed decisions in a timely and effective manner, to share professional expertise, and generally to be provided with staff support. At a minimum, information provided will include:

(1) Timetable for planning, development, and submission of proposals;

(2) Head Start policies, guidelines, and other communications from the Office of Child Development.

(3) Financial reports and statement of funds expended in the Head Start account; and

(4) Work plans, grant applications, and personnel policies for Head Start.

(c) The entire Head Start staff shall share responsibility for providing assistance in the conduct of the above activities. In addition, Health Services, Education, and Social Services staff shall contribute their direct services to assist the Parent Involvement staff. If staff resources are not available, the necessary resources shall be sought within the community.

§ 1304.5–5 Parent involvement plan content: parents, area residents, and the program.

The plan shall provide for:

(1) The establishment of effective procedures by which parents and area residents concerned

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which will contribute to the child's progress. In addition to regularly scheduled teacher conferences, parents should meet with other Head Start staff on an as-needed basis.

(a) Examples of specific communication techniques include newsletters; home visits; training sessions; and policy group meetings. These techniques should be programmed to occur on a regular and continuous basis—*e.g., monthly* newsletter, and *bimonthly* group meetings.

(b) Examples of ways in which this information may be transmitted include written handouts; written minutes of meetings; official correspondence; and oral presentations at policy group meetings and training sessions. Policy groups should have the opportunity to comment within a reasonable time.

(1) (2) (3) Content of the program *should* include:

PARENT INVOLVEMENT

PERFORMANCE STANDARDS

will be enabled to influence the character of programs affecting their interests,

(2) Their regular participation in the implementation of such programs and,

(3) Technical and other support needed to enable parents and area residents to secure on their own behalf available assistance from public and private sources.

GUIDANCE

- Training in all program components, in a way which allows parents to understand the Head Start program as an interrelated whole and to facilitate parent participation in the preparation of the work plan and budget.
- Ways in which parents can assist staff in setting the goals of the local program and the goals of other community institutions concerned with children and families, in a way which allows parents and staff to see those goals as an interrelated system.
- Training that occurs in a planned and continuous fashion, beginning with and continuing through the grantee's funding cycle, with adequate provision for parental input in the design and evaluation of the program.

APPENDIX A—PROGRAM OPTIONS FOR PROJECT HEAD START

This appendix sets forth policy governing the development and implementation of variations in program design by local Head Start programs.

N-30-334-1-00 Purpose

This chapter sets forth the policy governing the development and implementation of variations in program design by local Head Start programs.

N-30-334-1-10 Scope

This policy applies to all Head Start grantees and delegate agencies that operate or propose to operate a full year program which provides a set of services to the same child or the same group of children for less than six hours a day. The policy will be applied to all applications submitted by such grantees or delegate agencies on or after April 1, 1973.

N-30-334-1-20 Policy

A. GENERAL PROVISION

Beginning in the fourth quarter of FY 1973 (April 1973), Head Start programs will be permitted and encouraged to consider several program models in addition to the standard Head Start model and select the program option best suited to the needs of the children served and the capabilities and resources of the program staff. The program options that are to be available for local selection are as follows:

The standard Head Start model.
Variations in center attendance.
Double sessions.
Home-based models.
Locally designed variations.

In principle, the Office of Child Development will support any option or design model provided a community can demonstrate in an acceptable proposal that it will result in a quality child development program at reasonable cost and meet Head Start guidelines. Any program option proposed must demonstrate that it meets each of the following conditions:

1. All policies stated in the Head Start Manual for Head Start components must be adhered to, with the exception of those points detailed in the descriptions of each of the options under Special Provisions. This policy is not to be interpreted in any way which would lessen the force of the present Head Start policy which states that, "Programs in which enrollment does not reflect the racial or ethnic composition of disadvantaged families in the area may not be funded . . ." (Head Start Manual 6108-1, page 8).

2. The design and selection of program options is to be based on an assessment of the child development needs and resources of the broader community as well as the needs of the current enrollees and their families.

3. The assignment of children to programs is to be determined by assessing such factors as age or developmental level, family situation, handicaps, health or learning problems, and previous school experience. Discussion with all parents about specific needs of their children and how best to meet those needs must be a priority in such an assessment.

4. Proposed options must be justified as consistent with good developmental practices.

5. All parents whose children participate in any option must be represented in their parent-group organizations in accordance with the revised parent involvement guidelines of the Head Start Policy Manual of August 10, 1970.

6. Program options must receive the approval of the Head Start Policy Council prior to submission to OCD.

7. There must be a specific training plan for staff and volunteers for any option chosen. It should address itself to the requirements and goals of the specific program variations being implemented.

8. The number of hours spent in the Head Start center will vary depending on the option chosen. In all cases, the center activities are to maximize opportunities for meeting the child's developmental needs.

9. The application must demonstrate the ability to conduct the program option within the limits of the current funding level unless funds are added to the program from other sources. However, some options may enable programs to serve more children within the same funding level. Careful planning and analysis will be necessary to determine the total cost associated with serving additional children. In such planning, the following areas should be considered:

a. Additional medical-dental costs;
b. Increased costs due to separate scheduling and operating practices in the area of pupil and staff transportation;
c. Additional staff for home visits and similar supportive activities;
d. Need for additional recruitment effort;
e. Increased insurance costs;
f. Additions to parent activity funds.

B. SPECIAL PROVISIONS

1. The Standard Head Start Model

Continuation of the present five-day-per-week, center-based classroom format will be optional. Communities electing to continue this format are free to do so provided that they demonstrate through a careful assessment of their needs and capabilities that continuing the present program is in the best interests of the individual children and families served. If this assessment indicates that the present format is not adequately meeting local needs, the program is to consider whether these needs could be met more effectively by one or more of the other options.

2. Variations in Center Attendance

a. Head Start programs may elect to serve some or all children on a less than five-day-per-week basis. All children who attend Head Start on a partial basis must receive the same comprehensive developmental services as children attending the 5-day session, except as otherwise indicated. Shortened hours in the classroom may be supplemented by a parent education program or another option which would assist parents in developing their role as the first and most influential educators of their own children.

In planning for less than a five-day-week classroom schedule, careful consideration must be given to the underlying reasons for the attendance variations. Program planning must specifically address the following questions:

(1) What are the developmental needs of the child? Can they be met as effectively or more effectively by less than a five-day schedule?

(2) What are the needs and desires of the family? Would adjustment factors dictate consecutive-days attendance as opposed to, say, an every-other-day schedule?

(3) How does the curriculum plan fit the age and developmental needs of the children? Does the plan take into account differing needs of children of different ages, and varying needs of the same child over time?

(4) What kind of staffing pattern is required to obtain the program objectives?

b. In all situations where the children are in the center less than five days a week, the program must specify how they will receive comprehensive services. The following examples are illustrative of what this requires.

(1) One-third to one-half of the child's daily nutritional needs must be met each day he attends the center. Parents must, on request, be provided with simple, economical weekly menus and counseling on budgeting, food preparation and sanitation, as well as on how to involve children in food-related activities in the home.

(2) Provisions for complete medical and dental services must be made for all children in accordance with Head Start policies.

(3) Staff-family interaction, as central to the Head Start concept, must be included in any variation plan. Varied scheduling is to provide staff with new and additional opportunities for such interaction.

c. Staff utilization should contribute noticeably to program quality by maximizing staff talent, potential and expertise. Staff training goals must be identified and a training plan devised which will facilitate the implementation of the option. Such training should enable the staff to incorporate curriculum modifications necessary to accommodate the shorter week and to allow for the developmental differences between three-year-olds and five-year-olds.

d. Several attendance variation models are possible in planning the delivery of Head Start services. Attendance schedules must be devised for the children in accordance with their assessed needs. Proposals must describe the methods by which children are assigned to their schedules. The following examples indicate possible scheduling variations. The list is not meant to be exhaustive.

(1) The four-day-week schedule provides four days for center-based activities plus an additional day for center staff to perform special activities, such as:

- In-service training for staff, parents and volunteers.
- Special experiences for children.
- Home visits.
- Two days in small groups in homes with parent training by the staff.

(2) Split-session schedules: Two regularly enrolled groups, each meeting two days per week, with the fifth day set aside for such things as in-service training or working with small groups of parents or children with special needs.

3. Double Sessions

Head Start programs are permitted to operate double sessions as an option. In no case shall the addition of other children result in fewer services for children currently in the program. A program shall not be required, nor shall it be permitted, to conduct double sessions solely as a cost-saving device. In addition to the policies which apply to full-year, part-day program, the following conditions must be met when the double sessions option is utilized:

a. Provisions must be made for a one-hour break between doube-session classes when a single teaching staff conducts both halves of a double session. In addition, at least thirty minutes must be allotted prior to *each* session—whether or not a different teaching staff is used—to prepare for the session and set up the classroom environment, as well as to give individual attention to children entering and leaving the center. In some instances where schools serve as center sites, variations in scheduling double sessions may have to be considered.

b. The scheduling of children to attend morning or afternoon sessions must attempt to meet individual children's needs such as receptivity, necessity for naps, and other factors that might prevent full program benefit to some children.

c. Adequate time for staff consultation, planning (staff must plan for each session to meet the needs of particular children enrolled), in-service training and career development must be provided during the working schedule. In some cases, this can only be achieved by a variation in center attendance (e.g., a four-day-week for children).

d. Staff teaching both halves of a double session are not to have the primary responsibility for home visits unless some provision is made for substitute staff. In such cases, special provisions must be made for home visits.

e. Provisions must be made for an increase in supportive personnel and services in relation to the anticipated requirements of additional children and their families.

f. Provisions must be made for custodial services between sessions, including the cleaning of indoor and outdoor spaces.

g. Provisions must be made to maintain high food quality for both sessions. All children should have an opportunity to join in cooking and other food-related activities, preferably with the participation of the cook-manager.

4. Home-Based Models

Head Start grantees may elect to develop and incorporate a home-based model into their current program. Such models would focus on the parent as the primary factor in the child's development and the home as the central facility. These models may be designed along the lines of the Home Start demonstration programs initiated in fifteen communities in FY 1972 or on a model developed by the local community. The following conditions must be met by these grantees in implementing their programs:

a. Comprehensive Services

The same kinds of services which are available to children served in a center-based Head Start program will be available to children served by a home-based program. As in center-based programs, the home-based program must make every possible effort to identify, coordinate, integrate and utilize existing community resources and services (public, reduced-fee, or no-fee) in providing nutritional, health, social and psychological services for its children and their families.

(1) *Nutrition.*—In home-based programs, whenever feasible children should receive the same nutrition services as in center-based programs with priority emphasis on nutrition education aimed at helping parents learn to make the best use of existing food resources through food planning, buying and cooking. If periodic, regular or incidental group sessions for children are held, every effort should be made to prepare and serve a nutritious snack or meal. When food is not available to a family, the home-based program must make every effort to put the family in touch with whatever community organization can help supply food. In addition, parents should be informed of all available family assistance programs and should be encouraged to participate in them.

Nutrition education must recognize cultural variations in food preferences and supplement and build upon these preferences rather than attempt to replace them. Thus, food items that are a regular part of a family's diet will be a major focal point of nutrition education.

(2) *Health.*—Every effort must be made to provide health services through existing resources. Children in home-based programs are to receive the same health services as children in center-based programs.

As with the standard Head Start program, home-based programs shall provide linkages with existing health services for the entire family unit on an as-needed basis. However, Head Start funds may be used to provide health services only for the pre-school members of the family.

(3) *Psychological and Social Services.*—Home-based programs shall provide needed services through existing community resources or within the sponsoring Head Start program in accordance with existing Head Start policies.

b. Curriculum for Children

A major emphasis of the program must be to help parents enhance the total development (including cognitive, language, social, emotional and physical) of all their children.

Whatever the educational program or philosophy of a home-based program, it must have a plan or system for developing "individualized" or "personalized" education programs for its children.

In addition, programs must provide material, supplies and equipment (such as tricycles, wagons, blocks, manipulative toys and books) to foster the children's development in their homes as needed. Provision for such materials may be made through lending, cooperative or purchase systems.

Group socialization experiences must be provided on a periodic basis for all children in home-based programs. The proposal must specify what kind of developmental activities will take place in the group setting.

Furthermore, the education component—as well as all program components—must meet the needs of the locale by taking into account appropriate local, ethnic, cultural and language characteristics.

c. Parent Program

Home-based programs reflect the concept that the parent is the first and most influential "educator" and "enabler" of his or her own children. Thus, home-based programs are to place emphasis on developing and expanding the "parenting" role of Head Start parents.

Home-based programs must give both parents (or parent substitutes and other appropriate family members) an opportunity to learn about such things as various approaches to child rearing, ways to stimulate and enhance their children's total development, ways to turn everyday experiences into constructive learning experiences for children, and specific information about health, nutrition and community resources.

d. Evening and Weekend Services

It is suggested that the program make provision for evening and weekend services to families when needed.

e. Career Development

Programs must provide career development opportunities for staff. For example, training of staff should qualify for academic credit or other appropriate credentials whenever possible.

f. Service Delivery System

In their proposals, grantees must describe their system for delivering health, nutrition, psychological and other services that are not provided primarily by the in-home caregiver.

g. Staff Selection

Proposals must describe the program's system for selecting staff in accord with the responsibilities assigned by the program to the staff member. For example, the staff visiting homes must be:

(1) Fluent in the language used by the families they serve;
(2) Responsive listeners;
(3) Knowledgeable about human development, family dynamics, and needs of children;
(4) Knowledgeable about all program components;
(5) Knowledgeable about community resources.

h. Staff Development

Programs must submit a staff and volunteer recruitment plan and a training plan, including content of proposed pre- and in-service training programs, teaching method, descriptions of training staff or consultants, and provisions for continued in-service training. The career development plan must be designed to develop or increase staff member's knowledge about:

(1) Approaches to and techniques of working with parents;
(2) Other home-based or Home Start-like programs;
(3) All Head Start component areas.

i. Volunteers

As in all other Head Start programs, the home-based programs must encourage and provide opportunity for the use of volunteers.

5. Locally Designed Options

In addition to the above models, local programs may elect to design and propose other program options which they find well suited to meet the needs of individual children and the families in their communities. Proposals for local program options must adhere to the following guidelines:

a. They must be derived from an analysis of the present standard Head Start model and must represent a more effective approach to meeting the needs of children in the community.

b. They must be consistent with good developmental practices.

c. They must be consistent with Head Start performance standards and must ensure that all components of Head Start are effectively delivered, unless they are operated as an adjunct to a program which delivers the full range of Head Start services, or unless they represent a special program thrust or circumscribed effort such as:

(1) Health Start-type program or other services such as sickle cell or lead paint screening.
(2) Summer follow-on services for handicapped high risk or other children with special needs.

APPENDIX B—HEAD START POLICY MANUAL: THE PARENTS

This appendix sets forth policy governing the involvement of parents of Head Start children ". . . in the development, conduct, and overall program direction at the local level."

I–30–2 The Parents

A. INTRODUCTION

Head Start believes that the gains made by the child in Head Start must be understood and built upon by the family and the community. To achieve this goal, Head Start provides for the involvement of the child's parents and other members of the family in the experiences he receives in the child development center by giving them many opportunities for a richer appreciation of the young child's needs and how to satisfy them.

Many of the benefits of Head Start are rooted in "change". These changes must take place in the family itself, in the community, and in the attitudes of people and institutions that have an impact on both.

It is clear that the success of Head Start in bringing about substantial changes demands the fullest involvement of the parents, parental-substitutes, and families of children enrolled in its programs. This involvement begins when a Head Start program begins and should gain vigor and vitality as planning and activities go forward.

Successful parental involvement enters into every part of Head Start, influences other anti-poverty programs, helps bring about changes in institutions in the community, and works toward altering the social conditions that have formed the systems that surround the economically disadvantaged child and his family.

Project Head Start must continue to discover new ways for parents to become deeply involved in decision-making about the program and in the development of activities that they deem helpful and important in meeting their particular needs and conditions. For some parents, participation may begin on a simple level and move to more complex levels. For other parents the movement will be immediate, because of past experiences, into complex levels of sharing and giving. Every Head Start program is obligated to provide the channels through which such participation and involvement can be provided for and enriched.

Unless this happens, the goals of Head Start will not be achieved and the program itself will remain a creative experience for the preschool child in a setting that is not reinforced by needed changes in social systems into which the child will move after his Head Start experience.

This sharing in decisions for the future is one of the primary aims of parent participation and involvement in Project Head Start.

B. THE ROLE OF THE PARENTS

Every Head Start Program Must Have Effective Parent Participation. There are at least four major kinds of parent participation in local Head Start programs.

1. PARTICIPATION IN THE PROCESS OF MAKING DECISIONS ABOUT THE NATURE AND OPERATION OF THE PROGRAM.

2. PARTICIPATION IN THE CLASSROOM AS PAID EMPLOYEES, VOLUNTEERS OR OBSERVERS.

3. ACTIVITIES FOR THE PARENTS WHICH THEY HAVE HELPED TO DEVELOP.

4. WORKING WITH THEIR CHILDREN IN COOPERATION WITH THE STAFF OF THE CENTER.

Each of these is essential to an effective Head Start program both at the grantee level and the delegate agency level. Every Head Start program must hire/designate a Coordinator of Parent Activities to help bring about appropriate parent participation. This staff member may be a volunteer in smaller communities.

1. Parent Participation in the Process of Making Decisions About the Nature and Operation of the Program

Head Start Policy Groups

a. *Structure.*—The formal structure by which parents can participate in policy making and operation of the program will vary with the local administrative structure of the program.

Normally, however, the Head Start policy groups will consist of the following:

1. *Head Start Center Committee.* This committee must be set up at the center level. Where centers have several classes, it is recommended that there also be parent class committees.

2. *Head Start Policy Committee.* This committee must be set up at the delegate agency level when the program is administered in whole or in part by such agencies.

3. *Head Start Policy Council.* This Council must be set up at the grantee level.

When a grantee has delegated the entire Head Start program to one Delegate Agency, it is not necessary to have a Policy Council in addition to a Delegate Agency Policy Committee. Instead one policy group serves both the Grantee Board and the Delegate Agency Board.

b. *Composition.*—Chart A describes the composition of each of these groups.

Representatives of the Community (Delegate Agency level): A representative of neighborhood community groups (public and private) and of local neighborhood community or professional organizations, which have a concern for children of low income families and can contribute to the development of the program. The number of such representatives will vary depending on the number of organizations which should appropriately be represented. The Delegate Agency determines the composition of their committee (within the above guidelines) and methods to be used in selecting representatives of the community. Parents of former Head Start children may serve as representatives of the community on delegate agency policy groups. All representatives of the community selected by the agency must be approved by elected parent members of the committee. In no case, however, should representatives of the community exceed 50% of the total committee.

Chart A

Organization:	*Composition*
1. Head Start Center Committee-------	1. Parents whose children are enrolled in that center.
2. Head Start Policy Committee (delegate agency).	2. At least 50% parents of Head Start children presently enrolled in that delegate agency program plus representatives of the community.*
3. Head Start Policy Council (grantee)-	3. At least 50% parents of Head Start children presently enrolled in that grantee's program plus representatives of the community.**

Representatives of the Community (Grantee Agency level): A representative of major agencies (public and private) and major community civic or professional organizations which have a concern for children of low income families and can contribute to the program. The number of such representatives will vary, depending on the number of organizations which should appropriately be represented. The applicant agency determines the composition of the council (within the above guidelines) and the methods to be used in selecting representatives of the community. Parents of former Head Start children may serve as representatives of the community on grantee agency policy groups. All representatives of the community selected by the agency must be approved by elected parent members of the committee. In no case, however, should representatives of the community exceed 50% of the total committee or council.

Special Notes

1. All parents serving on policy groups must be elected by parents of Head Start children currently enrolled in the program.

2. It is strongly recommended that the community action agency board have representation from the Head Start Policy Council to assure coordination of Head Start activities with other CAA programs. Conversely, community action agency board representation on the Policy Council is also recommended.

3. It is important that the membership of policy groups be rotated to assure a regular influx of new ideas into the program. For this purpose, terms of membership must be limited to no more than three years.

4. No staff member (nor members of their families as defined in CAP Memo 23A) of the applicant or delegate agencies shall serve on the council or committee in a voting capacity. Staff members may attend the meetings of councils or committees in a consultative non-voting capacity upon request of the council or committee.

5. Every corporate board operating a Head Start program must have a Policy Committee or Council as defined by HEW. The corporate body and the Policy Committee or Council must not be one and the same.

6. Policy groups for summer programs present a special problem because of the difficulty of electing parent representatives in advance. Therefore, the policy group for one summer program must remain in office until its successors have been elected and taken office. The group from the former program should meet frequently between the end of the program and the election of new members to assure some measure of program continuity. These meetings should be for the purpose of (a) assuring appropriate follow up of the children (b) aiding the development of the upcoming summer Head Start program, (c) writing of the application, (d) hiring of the director and establishment of criteria for hiring staff and, when necessary (e) orientation of the new members. In short, the policy group from a former program must not be dissolved until a new group is elected. The expertise of those parents who have previously served should be used whenever possible.

c. *Functions.*—The following paragraphs and charts describe the minimum functions and degrees of responsibility for the various policy groups involved in administration of local Head Start programs. *Local groups may negotiate for additional functions and a greater share of responsibility if all parties agree.* All such agreements are subject to such limitations as may be called for by HEW policy. Questions about this should be referred to your HEW regional office.

(1) The Head Start Center Committee shall carry out at least the following minimum responsibilities:

(a) Assists teacher, center director, and all other persons responsible for the development and operation of every component including curriculum in the Head Start program.

(b) Works closely with classroom teachers and all other component staff to carry out the daily activities program.

(c) Plans, conducts, and participates in informal as well as formal programs and activities for center parents and staff.

(d) Participates in recruiting and screening of center employees within guidelines established by HEW, the Grantee Council and Board, and Delegate Agency Committee and Board.

(2) *The Head Start Policy Committee.* Chart B outlines the major management functions connected with local Head Start program administered by delegate agencies and the degree of responsibility assigned to each participating group.

In addition to those listed functions, the committee shall:

(a) Serve as a link between public and private organizations, the grantee Policy Council, the Delegate Agency Board of Directors, and the community it serves.

(b) Have the opportunity to initiate suggestions and ideas for program improvements and to receive a report on action taken by the administering agency with regard to its recommendations.

(c) Plan, coordinate and organize agency-wide activities for parents with the assistance of staff.

(d) Assist in communicating with parents and encouraging their participation in the program.

(e) Aid in recruiting volunteer services from parents, community residents and community organizations, and assist in the mobilization of community resources to meet identified needs.

(f) Administer the Parent Activity funds.

(3) *The Head Start Policy Council.* Chart C outlines the major management functions connected with the Head Start program at the grantee level, whether it be a community action or limited purpose agency, and the degree of responsibility assigned to each participating group.

In addition to those listed functions, the Council shall:

(a) Serve as a link between public and private organizations, the Delegate Agency Policy Committees, Neighborhood Councils, the Grantee Board of Directors and the community it serves.

(b) Have the opportunity to initiate suggestions and ideas for program improvements and to receive a report on action taken by the administering agency with regard to its recommendations.

(c) Plan, coordinate and organize agency-wide activities for parents with the assistance of staff.

(d) Approve the selection of Delegate Agencies.

(e) Recruit volunteer services from parents, community residents and community organizations, and mobilizes community resources to meet identified needs.

(f) Distribute Parent Activity funds to Policy Committees.

It may not be easy for Head Start directors and professional staff to share responsibility when decisions must be made. Even when they are committed to involving parents, the Head Start staff must take care to avoid dominating meetings by force of their greater training and experience in the process of decisionmaking. At these meetings, professionals may be tempted to do most of the talking. They must learn to ask parents for their ideas, and listen with attention, patience and understanding. Self-confidence and self-respect are powerful motivating forces. Activities which bring out these qualities in parents can prove invaluable in improving family life of young children from low income homes.

Members of Head Start Policy Groups whose family income falls below the "poverty line index" may receive meeting allowances or be reimbursed for travel, per diem, meal and baby sitting expenses incurred because of Policy Group meetings. The procedures necessary to secure reimbursement funds and their regulations are detailed in OEO Instruction #6803-1.

2. Participation in the Classroom as Paid Employees, Volunteers or Observers

Head Start classes must be open to parents at times reasonable and convenient to them. There are very few occasions when the presence of a limited number of parents would present any problem in operation of the program.

Having parents in the classroom has three advantages. It:

a. Gives the parents a better understanding of what the center is doing for the children and the kinds of home assistance they may require.

b. Shows the child the depth of his parents concern.

c. Gives the staff an opportunity to know the parents better and to learn from them.

There are, of course, many center activities outside the classroom (e.g., field trips, clinic visits, social occasions) in which the presence of parents is equally desirable.

Parents are one of the categories of persons who must receive preference for employment as non-professionals. Participation as volunteers may also be possible for many parents. Experience obtained as a volunteer may be helpful in qualifying for non-professional employment. At a minimum parents should be encouraged to observe classes several times. In order to permit fathers to observe it might be a good idea to have some parts of the program in the evening or on weekends.

Head Start Centers are encouraged to set aside space within the Center which can be used by parents for meetings and staff conferences.

3. Activities for Parents Which They Have Helped To Develop

Head Start programs must develop a plan for parent education programs which are responsive to needs expressed by the parents themselves. Other community agencies should be encouraged to assist in the planning and implementation of these programs.

Parents may also wish to work together on community problems of common concern such as health, housing, education and welfare and to sponsor activities and programs around interests expressed by the group. Policy Committees must anticipate such needs when developing program proposals and include parent activity funds to cover the cost of parent sponsored activities.

4. Working With Their Children in Their Own Home in Connection with the Staff of the Center

HEW requires that each grantee make home visits a part of its program when parents permit such visits. Teachers should visit parents of summer children a minimum of once; in full year programs there should be at least three visits, if the parents have consented to such home visits. (Education staff are now required to make no less than two home visits during a given program year in accordance with 1304.2-2(e)(4).) In those rare cases where a double shift has been approved for teachers it may be necessary to use other types of personnel to make home visits. Personnel, such as teacher aides, health aides and social workers may also make home visits with, or independently of, the teaching staff but coordinated through the parent program staff in order to eliminate uncoordinated visits.

Head Start staff should develop activities to be used at home by other family members that will reinforce and support the child's total Head Start experience.

Staff, parents and children will all benefit from home visits and activities. Grantees shall not require that parents permit home visits as a condition of the child's participation in Head Start. However, every effort must be made to explain the advantages of visits to parents.

Definitions as used on charts B and C

A. General Responsibility.—The individual or group with legal and fiscal responsibility guides and directs the carrying out of the function described through the person or group given operating responsibility.

B. Operating Responsibility.—The individual or group that is directly responsible for carrying out or performing the function, consistent with the general guidance and direction of the individual or group holding general responsibility.

C. Must Approve or Disapprove.—The individual or group (other than persons or groups holding general and operating responsibility, A and B above) must approve before the decision is finalized or action taken. The individual or group must also have been consulted in the decision making process prior to the point of seeking approval.

If they do not approve, the proposal cannot be adopted, or the proposed action taken, until agreement is reached between the disagreeing groups or individuals.

D. Must be Consulted.—The individual or group must be called upon before any decision is made or approval is granted to give advice or information but not to make the decision or grant approval.

E. May be Consulted.—The individual or group may be called upon for information, advice or recommendations by those individuals or groups having general responsibility or operating responsibility.

A = General responsibility
B = Operating responsibility
C = Must approve or disapprove
D = Must be consulted
E = May be consulted

	Chart B				Chart C			
	Delegate agency				Grantee agency			
Function	Board	Executive director	Head Start policy committee	Head Start director	Board	Executive director	Head Start policy council	Head Start director
I. Planning:								
(a) Identify child development needs in the area to be served (by CAA* if not delegated).	A	B	D	D	A	B	D	D
(b) Establish goals of Head Start program and develop ways to meet them within HEW guidelines.	A	C	C	B	A	C	C	B
(c) Determine delegate agencies and areas in the community in which Head Start programs will operate.	------	------	------	------	A	D	C	B
(d) Determine location of centers or classes	A	D	C	B	------	------	------	
(e) Develop plans to use all available community resources in Head Start.	A	D	C	B	A	D	C	B
(f) Establish criteria for selection of children within applicable laws and HEW guidelines.	------	------	------	------	A	C	C	B
(g) Develop plan for recruitment of children	A	C	C	B	------	------	------	
II. General Administration:								
(a) Determine the composition of the appropriate policy group and the method for setting it up (within HEW guidelines).	A	B	C	D	A	B	C	D
(b) Determine what services should be provided to Head Start from the CAA* central office and the neighborhood centers.	------	------	------	------	A	B	C	D
(c) Determine what services should be provided to Head Start from delegate agency.	A	B	C	D	------	------	------	------
(d) Establish a method of hearing and resolving community complaints about the Head Start program.	D	C	A	B	D	C	A	B
(e) Direct the CAA* Head Start staff in day-to-day operations.	------	------	------	------	E	A	E	B
(f) Direct the delegate agency Head Start staff in day-to-day operations.	E	A	E	B	------	------	------	
(g) Insure that standards for acquiring space, equipment, and supplies are met.	A	D	D	B	A	D	D	B
III. Personnel administration:								
(a) Determine Head Start personnel policies (including establishment of hiring and firing criteria for Head Start staff, career development plans, and employee grievance procedures).								
Grantee agency	------	------	------	------	A	C	C	B
Delegate agency	A	C	C	B	------	------	------	
(b) Hire and fire Head Start Director of grantee agency.	------	------	------	------	A	B	C	
(c) Hire and fire Head Start staff of grantee agency	------	------	------	------	E	A	C	B
(d) Hire and fire Head Start Director of delegate agency.	A	B	C	------	------	------	------	
(e) Hire and fire Head Start staff of delegate agency.	E	A	C	B	------	------	------	
IV. Grant application process:								
(a) Prepare request for funds and proposed work program.								
Prior to sending to CAA*	A	C	C	B	------	------	------	
Prior to sending to HEW	------	------	------	------	A	C	C	B
(b) Make major changes in budget and work program while program is in operation.	A	C	C	B	A	C	C	B
(c) Provide information needed for prereview to policy council.	A	D	C	B	------	------	------	
(d) Provide information needed for prereview to HEW.	------	------	------	------	A	D	C	B
V. Evaluation: Conduct self-evaluation of agency's Head Start program.	A	D	B	D	A	D	B	D

*CAA or general term "grantee".

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